

357008

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <input type="checkbox"/> ESTIMATED <input type="checkbox"/> 12 4 1985										2b. HOUR 4:20 PM	
1. DECEASED NAME (TYPE OR PRINT)		BENJAMIN OTIS AIKEN											
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7/19/1899		6. AGE (IN YEARS) (LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 4 1985		2d. HOUR 4:20 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.							
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Elem. School					
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Accident		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 1 Box 18 21520 Accident Md.					
14. FATHER'S NAME FIRST MIDDLE LAST Rufus JUDSON Aiken		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora --- Hester		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW IX 219-36-8375		17. INFORMANT Mrs. Hildegard Aiken Accident, MD 21520					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Francisco Reyes		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER				DATE SIGNED					
EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes		ADDRESS 900 Seton Dr. Cumberland Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/7/85		23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Accident, Garrett, MD 21502					
24. FUNERAL DIRECTOR NAME A. J. Newman		ADDRESS Grantsville, MD 21536		25a. DATE REC'D BY REGISTRAR DEC 11 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall							

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BOALS FUNERAL HOME  
 1- STATE 111 CHURCH ST. WESTERNPORT, MD  
 REGISTRAR DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAUL FERDINAND AMANN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 13, 1985		2b. HOUR 6:45 A.M.						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 30 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? usa		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Westvaco		12b. KIND OF BUSINESS OR INDUSTRY Paper			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 274 Main St. 21562		
14. FATHER'S NAME FIRST MIDDLE LAST John Amann				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Kady							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW2		17. INFORMANT Mrs. Elizabeth Amann		ADDRESS Westernport, Md 21562				
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>George Branga MD.</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12-16-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE V. MAZZOCCO, MD					22e. ADDRESS BMG 912 SETON DRIVE CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/16/85		23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md.				
24. FUNERAL DIRECTOR Boals Funeral Service Westernport, Md. 21562					25a. DATE REC'D. BY REGISTRAR DEC 20 1985		25b. REGISTRAR'S SIGNATURE <u>John Taylor</u>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #1 and #2 and #3 and #4 and #5 and #6 and #7 and #8 and #9 and #10 and #11 and #12 and #13 and #14 and #15 and #16 and #17 and #18 and #19 and #20 and #21 and #22 and #23 and #24 and #25 and #26 and #27 and #28 and #29 and #30 and #31 and #32 and #33 and #34 and #35 and #36 and #37 and #38 and #39 and #40 and #41 and #42 and #43 and #44 and #45 and #46 and #47 and #48 and #49 and #50 and #51 and #52 and #53 and #54 and #55 and #56 and #57 and #58 and #59 and #60 and #61 and #62 and #63 and #64 and #65 and #66 and #67 and #68 and #69 and #70 and #71 and #72 and #73 and #74 and #75 and #76 and #77 and #78 and #79 and #80 and #81 and #82 and #83 and #84 and #85 and #86 and #87 and #88 and #89 and #90 and #91 and #92 and #93 and #94 and #95 and #96 and #97 and #98 and #99 and #100 and #101 and #102 and #103 and #104 and #105 and #106 and #107 and #108 and #109 and #110 and #111 and #112 and #113 and #114 and #115 and #116 and #117 and #118 and #119 and #120 and 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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) PRUDY L. ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR December 7, 1985			2b. HOUR 7:35 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 15 1895		6. AGE (IN YEARS, LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE W.Va.			13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William E. Parks			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Hall			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 236-76-0996			17. INFORMANT Mr. Herbert Anderson			ADDRESS 97 James St. Keyser, W.Va. 26726			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intractable congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced CAD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Failure</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>multiple pulmonary embolism, COPD</u>	

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that on (this hospital) attended the deceased from <u>12/1/85</u> to <u>12/7/85</u> , that <u>1</u> (we) last saw the deceased alive on <u>12/7/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <u>1</u> (we) (did) (do) not wish the body after death.							
22b. SIGNATURE <u>Sham A. Mather</u>		DEGREE		22c. DATE SIGNED <u>12/8/85</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Raver	
22e. ADDRESS 500 Memorial Ave., Memorial Med. Bldg. Cumberland, MD 21502							

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Dec. 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Sylvan Abbey Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Clearwater Fla.	
24. FUNERAL DIRECTOR <u>Donald W. McKenzie</u>		ADDRESS 111 S. Mineral		25a. DATE REC'D. BY REGISTRAR DEC 13 1985		25b. REGISTRAR'S SIGNATURE <u>John Anderson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the folder and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. IMPORTANT: If item 21 is marked, item 18 should show any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARZEIGLER FUNERAL HOME  
HYNDMAN, PA

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GOLDIE MARIE APPLING</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 5, 1985</b>		2b. HOUR <b>7:35 AM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 / 07 / 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>PA</b>	13b. COUNTY <b>Bedford</b>	13c. CITY OR TOWN <b>Hyndman</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Box 579, R D 1 / 15545</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Divelbiss</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cassie Belle Deneen</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213 22 3491</b>		17. INFORMANT ADDRESS <b>Linda Appling, Box 579, RD, Hyndman, PA 15545</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure &amp; pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>chronic emphysema, diabetes</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11/16</b> , 19 <b>85</b> , to <b>12/5</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>12/5</b> , 19 <b>85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Renato Espina</b>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/5/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RENATO ESPINA, MD</b>			22e. ADDRESS <b>907 SETON DRIVE, CUMBERLAND, MD 21502</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/7/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, MD</b>	
24. FUNERAL HOME <b>Harvey H. Zeigler, Hyndman, PA</b>			ADDRESS <b>15545</b>	25a. DATE REC'D. BY REGISTRAR <b>DEC 10 1985</b>	25b. REGISTRAR'S SIGNATURE <b>John F. ...</b>

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ALLIANCE COUNTY

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the permit to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma or accident, the medical examiner must be notified at once.

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(VRA 15, 4)

SILCOX MERRITT FUNERAL HOME

STATE OF MARYLAND

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1- 404 DECATOR STREET  
STATE REGISTRAR CUMBERLAND, MD 21502DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELIZABETH EDNA BARRY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 11, 1985</b>		2b. HOUR <b>1:50 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 20 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES W. MILLER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BESSIE LEE VALENTINE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-10-6986</b>		17. INFORMANT ADDRESS <b>JAMES P. BARRY 9 RIDGEWAY TERRACE CUMBERLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute anterior Myocardial Infarct</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arterio Cardiacogenic stroke</i> <i>fx of CAD &amp; peripheral MI</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic atherosclerosis</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Drucke type II</i>					
19a. DATE OF OPERATION <i>12/9</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/11</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>V. Rual Felipa</i>		DEGREE		22c. DATE SIGNED <i>12/11/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. RUAL FELIPA, MD</b>		22e. ADDRESS <b>925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>DEC 13 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST MICHAEL'S CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FROSTBURG ALLEGANY MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.</b>			25. DATE REC'D. BY REGISTRAR <b>DEC 16 1985</b> REGISTRAR'S SIGNATURE <i>John Davidson</i>		

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SILCOX HERRITT FLORAL HOME  
408 DECATOR STREET  
CUMBERLAND, MD 21502

ELIZABETH BARN BARRY  
DECEMBER 11, 1962 1:50A

ALLEANY COUNTY

SACRED HEART HOSPITAL

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*[Faint handwritten notes and signatures, including "12/11/62" and "12/11/62"]*

V. RIAL FELIX, MD 622 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

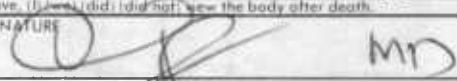
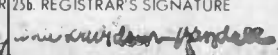
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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SUSAN ADELE BATES			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 9, 1985		2b. HOUR 11:45A M						
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR June 18 1932		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher's Aide			12b. KIND OF BUSINESS OR INDUSTRY Education		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland						13c. COUNTY Allegany		13d. CITY OR TOWN Cumberland		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest O. Bates						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence --- Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-30-1945		17. INFORMANT ADDRESS Cumberland, Md. 21502 Nancy Bates 355 Williams St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Ca. tongue</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.											
22b. SIGNATURE  MD						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ZAMAN						22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-12-85		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial p.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.				
24. FUNERAL DIRECTOR NAME Leasure-Stein Inc. 230 Baltimore Ave.						24a. ADDRESS Cumberland, Md. 21502		25a. DATE REC'D. BY REGISTRAR DEC 13 1985		25b. REGISTRAR'S SIGNATURE 	



Admission to target

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within four hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and identified as such to the funeral director, page 3 could be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. FOR STATE REGISTRAR HAFER FUNERAL HOME 1302 NATIONAL HWY. LAVALE, MD 21502		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 15, 1985	
1. DECEASED NAME (TYPE OR PRINT) PAUL THEODORE BECKWITH		2b. HOUR 2:37 A.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 11-29-1903	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rigger	12b. KIND OF BUSINESS OR INDUSTRY Manufacturing
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Ohio	13b. COUNTY Trumbull	13c. CITY OR TOWN Niles	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME Frank	15. MOTHER'S MAIDEN NAME Emma	13e. STREET ADDRESS / ZIP CODE 10 Sheridan Ave. 21502	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 220-10-9091	17. INFORMANT ADDRESS Agnes S. Beckwith same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Cerebral Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral CVA. Carotid artery sclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. Diabetes mellitus; Septicemia; Congestive Failure; Acute Renal Failure, old age			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/6/85, 1985, to 12/15, 1985, that (I) (we) last saw the deceased alive on 12/14, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE S. L. Sandhir MD	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/15/1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIKANDER SANDHIR	22e. ADDRESS 48 TARN TERRACE FROSTBURG, MD 21532		
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE Dec. 17, 85	23c. NAME OF CEMETERY OR CREMATORY Pineview	23d. LOCATION CITY OR TOWN COUNTY STATE Warren Trumbull, Ohio
24. FUNERAL DIRECTOR NAME John J. Hafer LaVale, MD. 21502		25a. DATE REC'D. BY REGISTRAR DEC 19 1985	

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>KATHLEEN MAE BIERMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 16, 1985</b>		2b. HOUR <b>1:45P.M.</b>						
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09-08-1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>R.F.D. 4 - Mexico Farms/21502</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clifton E. Willison</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora M. Emerick</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>217-10-4783</b>		17. INFORMANT ADDRESS <b>Mr. Frederick W. Bierman, Jr., Cumberland, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF COLON WITH METASTASIS.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. TORRES</b>						22e. ADDRESS <b>Memorial Hospital Medical Building Cumberland, Maryland 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-19-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>James F. Scarpelli, Cumberland, MD 21502</b>						25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers, pages 1 and 2 (which will be filed with the death certificate) with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edward Charles Bock</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 13 85</b>			2b. HOUR <b>747 P.M.</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 16, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Village Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Law Mower Repair Shop</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>430 Valley St. 21502</b>	
14. FATHER'S NAME FIRST LAST <b>George Bock</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara O'Baker</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-10-1498</b>		17. INFORMANT ADDRESS <b>Mrs. Elizabeth Bock, Cumberland, Md. Wife</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>George Breza MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12-16-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Breza, MD</b>				22e. ADDRESS <b>912 Seton Drive, Cumberland, Md. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL 15 CFR 111 <b>Burial</b>		23b. DATE <b>12-16-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 19 1985</b>					
25b. REGISTRAR'S SIGNATURE <b>John H. ...</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death information from pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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12-13-82 744

Edward Charles Boe

12-13-82	744	Boe	Edward Charles	12-13-82	744
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12-13-82	744	Boe	Edward Charles	12-13-82	744
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12-13-82	744	Boe	Edward Charles	12-13-82	744
12-13-82	744	Boe	Edward Charles	12-13-82	744
12-13-82	744	Boe	Edward Charles	12-13-82	744



12-13-82 744

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
1 - STATE REGISTRAR 1302 NAT. HWY. LAVALE, MD CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ALICE JUNE BOWMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 9, 1985</b>		2b. HOUR <b>2:35 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 11, 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cresaptown</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>14906 Lone Oak St./21502</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Vernon Kesecker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Estella Fearnow</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220287670</b>		17. INFORMANT ADDRESS <b>Roger D. Bowman - same as above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Metastases</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Cancer of breast = Met.</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12-02-1985</b> , to <b>12-9-1985</b> , that (I) (we) lost the deceased alive on <b>12-9-1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>John Mehan</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL STAFF</b> <input type="checkbox"/> <b>PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>12-10-85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN MEHANNA, M.D.</b>				22e. ADDRESS <b>909-B SETON DRIVE CUMBERLAND, MD. 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/12/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Alleg., MD</b>		
24. FUNERAL DIRECTOR NAME <b>John J. Hafer, Jr.</b>				ADDRESS <b>LaVale, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 13 1985</b>		
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

BP

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WATER PLANT, NEW

1502 NAT. HWY. LAVAL, CT.

ALICE JUNE KIMM 2:35 P

Female White 12. 11, 1953 25

ALLEGANY COUNTY

LA

W. V.

Quabband Sacred Heart Hospital Houserville, Ohio Home

Quabband Allegany, Pennsylvania 14906 Jane Can St. 14906

Harry Vernon Jackson Houserville, Ohio

No 14906 Jane Can St. 14906 - same as above

600-B SEVEN DRIVE CLERLAND, MD. 21502

JOHN KENNEDY, N.D.

John J. Heller, Jr. La Vale, MD

12/12/53 Sunset New York, New York, Alleg. MD

07/84  
25M

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND GENERAL SERVICES, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR OTHER DISPOSAL.

DHMH - 17  
(VR A15 ME (5))

1- FOR  
STATE  
REGISTRAR

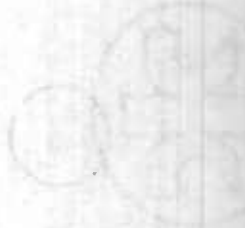
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		X MONTH		DAY		YEAR		2b. HOUR					
IDA		H.		BRODBECK				12/5		185		PM		6:30		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
FEMALE		WHITE		3/15/93		92 YRS.		MONTHS		DAYS		12/5		19		856:30		PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				NEVER MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND				U.S.A.				WIDOWED				X				ALLEGANY					
11. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION				12b. KIND OF BUSINESS OR INDUSTRY									
NATIONAL				RT. 1, BOX 344, FROSTBURG				HOUSEWIFE				OWN HOME									
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS					
MARYLAND				ALLEGANY				NATIONAL				YES				NO					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT					
WILLIAM				JANE				NO				214-01-6697				MRS. NAOMI INGRODI, RT. 1, BOX 344					
18. CAUSE OF DEATH				19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
PART I DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
CANCER OF THE RECTUM WITH METASTASIS																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)				DUE TO, OR AS A CONSEQUENCE OF													
				(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED				21d. INJURY OCCURRED									
UNDERLYING				HOUR A.M.				ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2				WHILE AT WORK									
OR CONTRIBUTING				P.M.								NOT WHILE AT WORK									
CAUSE OF DEATH				19																	
21e. PLACE OF INJURY				21f. LOCATION				CITY OR TOWN				COUNTY									
(AT HOME, STREET, FACTORY, FARM, ETC.)				STREET								STATE									
22a. I certify that I took charge of the remains described above, held an				Autopsy				Inspection				Inquiry				and in my opinion					
death resulted from:				Natural causes				Accident				Suicide				Homicide					
				X																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED									
FRANCISCO REYES				DEPUTY								12/5/85									
EXAMINER'S NAME				ADDRESS				CITY OR TOWN				COUNTY									
(TYPE OR PRINT)				900 Seton Dr.				Cumberland Md.				ALLEGANY MD									
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
(SPECIFY)				12/8/85				FROSTBURG MEM. PARK				21502									
Burial				FROSTBURG				FROSTBURG				ALLEGANY									
23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE				23g. REGISTRAR'S SIGNATURE				23h. REGISTRAR'S SIGNATURE									
12/8/85				SOWERS FUNERAL HOME				FROSTBURG				FROSTBURG									

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		KNOWN ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Georgia		May		Burdock				12		18		19		85				9:50	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
female	white	02-14-1918		67 YRS.						12		18		19		85		9:50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
WV		USA		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		Allegany						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Cumberland		Sacred Heart Hospital		clerk		Dept. Store													
13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
MD		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		925 Grand Avenue/21502											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Walter Glaze, Sr.		May Davy																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
no		800-05-4394		Mrs. Anna May Swauger		Bowling Green, MD													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a)		Mycardial infarction due to																	
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		arteriosclerotic heart disease															
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																	
20. AUTOPSY?																			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED													
Giovanni Mastrangelo		Deputy				12-18-85													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
Giovanni Mastrangelo, M.D.		900 Seton Drive, Cumberland, MD 21502																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION													
Burial		12-21-1985		Rose Hill Cemetery		Thomas													
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S NAME											
Scarpelli Funeral Home		Cumberland, MD 21502				DEC 23 1985		Giovanni Mastrangelo											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (SEE PAGE 2) 2. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES ROBERT CANFIELD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 24, 1985</b>			2b. HOUR <b>10:25 A</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03-24-1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ret. brakeman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION):									
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>220 W. Oldtown Road/21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James R. Canfield</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Melissa Ann Bright</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1924-1928 214-05-8443</b>			17. INFORMANT ADDRESS <b>Mrs. Emma J. Canfield, Cumberland, MD - wife</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic shock.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Massive Aortic MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Hypothyroidism, Dehydration</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/24/85</b> to <b>12/24/85</b> , that (I) (we) last saw the deceased alive on <b>12/24/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. Ranjithan</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12/24/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Ranjithan</b>						22e. ADDRESS <b>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-27-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg MemorialPk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg Allegany MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>James F. Scarpelli, Cumberland, MD 21502</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 30 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

MEDICAL CERTIFICATION

85

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove correct papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET GRACE CATHELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 1, 1985</b>		2b. HOUR <b>3:50 A.M.</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 9, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W.Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>W.Va.</b>			13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Keyser</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>62 Vernon St. 99999 26726</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George --- Cox</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nan --- (Unknown)</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>234-56-5212</b>	
17. INFORMANT <b>Mr. William E. Cathell</b>				ADDRESS <b>62 Vernon St. Keyser, W.Va.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PROBABLY MYO CARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CAID -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEVERE CHRONIC BRONCHITIS &amp; COR PULMONIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>SEVERE CHRONIC BRONCHITIS &amp; COR PULMONIS</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 30 1985</b> to <b>DEC 1 1985</b> that (I) (we) last saw the deceased alive on <b>DEC 1 1985</b> , and that in <b>6</b> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death.											
22b. SIGNATURE <b>Dr. James Raver</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>12/3/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. James Raver</b>				22e. ADDRESS <b>Memorial Hospital Medical Bldg. Cumberland, MD 21502</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/3/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rost Lawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LaVale Allegany Md.</b>					
24a. NAME OF FUNERAL HOME <b>Markwood-McKenzie</b>				111 S. Mineral St. Keyser, W.Va. 26726		25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1985</b>					
25b. REGISTRAR'S SIGNATURE <b>John Taylor</b>											

DHMH - 16 60M 7/B4  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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GREEN MOTION PICTURE



12/31

DEC 31 1950

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

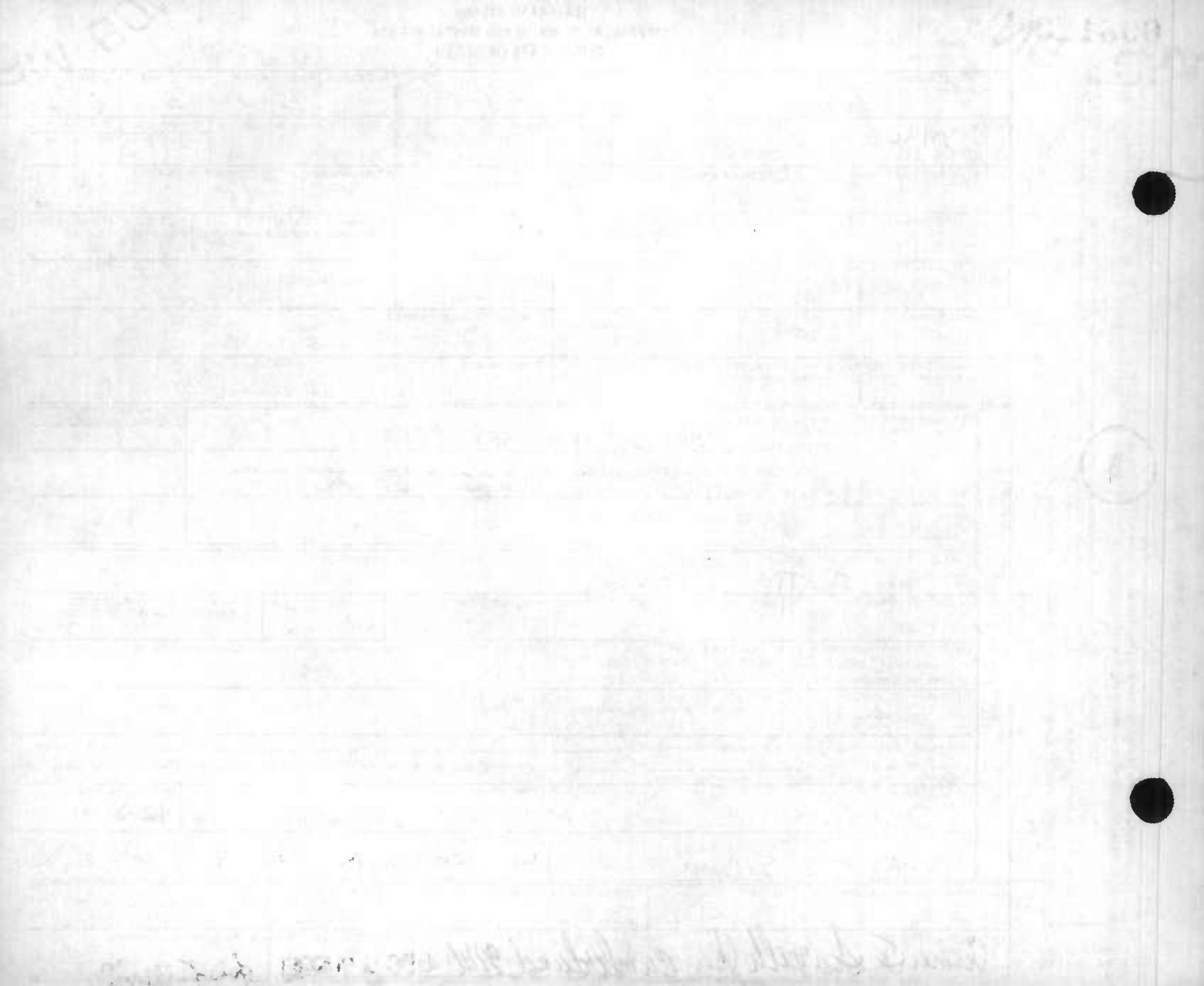
1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANTHONY S CLAY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12-21-85</b>		2b. HOUR <b>6:35 A.M.</b>	
3 SEX <b>MALE</b>	4 RACE <b>white</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>06-21-1907</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD	
10 CITY OR TOWN OF DEATH <b>Frostburg</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Village Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Leo Clay</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Potts</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214-05-9384</b>		17 INFORMANT ADDRESS <b>Mrs. Mary Clay, Cumberland, MD - wife</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMA OF PROSTATE</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>AORTIC STENOSIS</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alone on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>H. S. Siddhan</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12-21-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HARJIT S. SIDDHAN</b>		22e. ADDRESS <b>48 TARN TERRACE, FROSTBURG MD, 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-24-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	
24 FUNERAL DIRECTOR NAME <b>James J. Scarpelli Jr.</b>		ADDRESS <b>Cumberland Md</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 27 1985</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP

DHMM-16 25M  
(VRA 15, 4) 1/79



345138

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE JANE LAST COLEMAN			2a. DATE OF DEATH MONTH DAY YEAR December 2, 1985		2b. HOUR 7:25 AM					
3. SEX FEMALE		4. RACE NEGROE		5. DATE OF BIRTH MONTH DAY YEAR 10/3/20		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY HOME PRIVATE			
13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 83 BEALL ST. 21532	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY CARTER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY THOMPSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A. 220-03-7641		17. INFORMANT FROSTBURG, MD 21532 PAUL E. COLEMAN, 83 BEALL ST.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Metastatic DUE TO, OR AS A CONSEQUENCE OF Breast Ca. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i>			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/2/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Qamar Zaman			22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 12/5/85		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM PARK		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD			
24. FUNERAL DIRECTOR SOWERS FUNERAL HOME			60 W. MAIN ST. FROSTBURG			25a. DATE REC'D. BY REGISTRAR DEC 10 1985				
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits are carbon papers. Page 1 and 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

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352138

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY LOU COLEMAN</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>12 4 19 85</b>		2b. HOUR <b>8: M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>2</b> YEAR <b>20</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>65</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
7c. DATE PRONOUNCED DEAD <b>12 5 85</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b>		MD.	
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FROSTBURG HEIGHTS APTS.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		13. STREET ADDRESS <b>100 HONEYSUCKLE LANE</b>			
14. FATHER'S NAME FIRST <b>LEWIS</b> MIDDLE <b>BRADY</b> LAST <b>JOHNSTON</b>		15. MOTHER'S MAIDEN NAME FIRST <b>GRACE</b> MIDDLE <b>GLADYS</b> LAST <b>SMITH</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>N.A.</b>		17. INFORMANT <b>FROSTBURG, MD 21532</b>		17. INFORMANT <b>MARY ANN MINNICK, RT. 2, BOX 324</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Francisco Reyes</b>		TITLE (SPECIFY) <b>DEPUTY</b>		DATE SIGNED <b>12/5/85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Francisco Reyes</b>		ADDRESS <b>900 Seton Dr. Cumberland Md. 2</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/7/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK FROSTBURG ALLEGANY MD</b>	
23d. LOCATION CITY OR TOWN <b>FROSTBURG</b>		COUNTY <b>ALLEGANY</b>		23e. DATE REC'D. BY REGISTRAR <b>DEC 10 1985</b>	
23f. REGISTRAR'S SIGNATURE <b>John Davidson</b>		23g. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXEMPTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

151350

*[Illegible handwritten signature]*

352001

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ALFRED JOSEPH COMER, SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 9, 1985</b>		2b. HOUR 3:10 P. M.		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 11, 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic-Western Maryland R.R.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>West Va.</b>				13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Ridgeley</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Emil B. Comer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary - Ross</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>117 Main Street / 26753</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>--</b>		16b. SOCIAL SECURITY NO. <b>235-52-5023</b>		17. INFORMANT <b>Helen Comer - Address same as #13 above.</b>		ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) **G-I Bleeding**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) **Ch. of lung**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-30</b> , 19 <b>85</b> , to <b>12-9</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>12-9</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. Q. Zaman</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/9/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Q. Zaman</b>				22e. ADDRESS <b>Memorial Hospital medical Building Cumberland, MD 21502</b>			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-12-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland-Allegany Co., MD.</b>	
24. FUNERAL DIRECTOR NAME <b>George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, MD. 21502</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 16 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 could be detached for use on the burial-transit permit. Then please return completed page 3 to the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called upon.



Gen. of ...



*Handwritten signature*

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1/1/12

93814 100100 2702

OWD

WATF/H

353103

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John E. Crites</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 10 85</b>		2b. HOUR P M <b>9:50 P M</b>						
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 3, 1903</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>82</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cumberland,</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lions Manor Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Rail Road</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>424 Columbia St. 21502</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Allen Crites</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa F. Zerk</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>705-12-2354</b>		17. INFORMANT ADDRESS <b>Eleanor Crites Oldtown, MD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the lungs</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>C.O. p.D. - Severe.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>10-18</b> , 19 <b>85</b> , to <b>12-10</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>12-9</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>V. A. Ranjithan</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. A. Ranjithan, M. D.</b>				22e. ADDRESS <b>LMNH Seton Drive, Cumberland, MD 21502</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 13, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>William G. Knight Cumberland, MD</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>LEC 17 1985</b>					

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in the funeral director's page 2, should be detached for use on the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

303133



Burial  
Dec. 13, 1983 Sunset Memorial P. Cumberland Allegany MD  
William G. Night  
Cumberland, MD

Male  
White  
May 3, 1903  
83  
USA  
W. Va.  
Cumberland,  
MD  
Allegany Cumberland X  
424 Columbia St. 21502  
Crites  
Kosa  
F.  
York  
Eleanor Crites Oldtown, MD  
No

Machinist  
Rail Road



315161

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
IRENE CECELIA CRITZMAN			December 5, 1985			2:03p.m.		
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female	White	February 28 1905	80 YRS			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
Maryland			USA			9. BALTIMORE CITY OR COUNTY OF DEATH		
Cumberland			Memorial Hospital			Allegany MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Cumberland			Memorial Hospital			Beautician		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Allegany			Cumberland, Md.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
David H. Coffman			Mary Gumm			No		
16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
214-32-3278			Wanda Mellon-Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Basophilic Carcinoma</u>								?
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u>								2-5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTED <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION				
WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <u>11/19/85</u> 19 to <u>12/5/85</u> 19, that (I) (we) last saw the deceased alive on <u>12/5/85</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death.)								
22a. SIGNATURE				DEGREE				22b. DATE SIGNED
<u>Dr. Howard Diener</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				<u>12/5/85</u>
22c. PHYSICIAN'S NAME (TYPE OR PRINT)				22d. ADDRESS				
Dr. Howard Diener				Memorial Hospital Medical Bldg. Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		12-7-85		Zion Memorial Park		Cumberland Allegany Md.		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Cumberland, Maryland 21502				DEC 9 1985		<u>[Signature]</u>		
Leasure-Stein Inc. 230 Baltimore Ave.								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





314083

GEORGE UPCHURCH FUNERAL HOME STATE OF MARYLAND  
 202 GREEN STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 1- REGISTRAR CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) WILLIAM LEROY DAILEY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 4, 1985		2b. HOUR 2:40P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 6, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chef-SS. Peter & Paul Cath. Ch.		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Earl Dailey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucille Edenhart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 214 07 5136		17. INFORMANT ADDRESS Josephine Dailey-Address same as #13 above.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetes; Ch 7 Lung</u>					
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> , 19 <u>85</u> , to <u>12/4</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/4</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Renato Espina</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/4/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RENATO ESPINA MD		22e. ADDRESS 907 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-7-85		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-ALLEGANY Co.-Md.		24. FUNERAL DIRECTOR NAME ADDRESS George-Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, Md. 21502			
25a. DATE REC'D. BY REGISTRAR DEC 6 1985		25b. REGISTRAR'S SIGNATURE <u>W. W. Wadsworth</u>			

310033

WILLIAM LEROY DALLAY  
DECEMBER 11, 1922

ALLIANCE COLLEGE

SACRED HEART HOSPITAL

210 07 2120

CO. of 1st

107 07 2120

RENTAL 25 DOLLARS  
507 SEVEN DRIVE, OAKLAND, MD 21202

DEC 11 1922

364061

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, forward it to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner will be asked to autopsied on death.)

DHMH - 16 60M 7/84  
(VRA 15, 4)

## BOALS FUNERAL HOME

STATE OF MARYLAND

1 - STATE 111 CHURCH STREET  
REGISTRAR WESTERNPORT, MD 21562

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GERALDINE VICTOR DAWSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 19, 1985</b>		2b. HOUR <b>3:00P M</b>
1. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 9 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) COUNTRY <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.	
11. CITY OR TOWN OF DEATH <b>Cumberland</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sew Rite</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sewing</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Westernport</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>Rt. 1 Box 11 21562</b>					
4. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin H. Wilt</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Violet Youst</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-38-6295</b>		17. INFORMANT ADDRESS <b>Mr. Lutian Dawson Westernport, Md. 21562</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Inferior M.I.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD - Diabetes</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-9</b> 19 <b>85</b> to <b>12-19</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>12-19</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Uriel Velandia</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12-21-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>URIEL VELANDIA</b>		22e. ADDRESS <b>924 SETON DRIVE CUMBERLAND, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/22/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>	
23d. LOCATION <b>Barton</b>		23e. COUNTY <b>Allegany Md.</b> STATE			
24. FUNERAL DIRECTOR NAME <b>Boals Funeral Service</b>		24b. ADDRESS <b>Westernport, Md. 21562</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 26 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

BP

126739

RECEIVED 19, 1965 3:00P

352050

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PEARL A. DELBUSSO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 7, 1985</b>			2b. HOUR MIN. <b>10:30A.</b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 15, 1918</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baker-Ali Ghan Shrine</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>697 Gephart Drive / 21502</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas P. Ansell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Malinda - Pirl</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>171-14-5831</b>	
17. INFORMANT ADDRESS <b>Dominic Del Busso - Address same as #13.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intractable Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ischemic Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Robotic Prosthetic</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> 19 <u>85</u> , to <u>12-7</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12-7</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE <u>Dr. Barrera</u>						DEGREE			22c. DATE SIGNED <u>12-9-85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. BARRERA</b>						22e. ADDRESS <b>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-9-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Meml. Gardens</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>LaVale-Allegany-Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>George-Upchurch Funeral Home, P.A.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 16 1985</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
202 Greene Street-Cumberland, Maryland 21502											

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or filled in, there is any injury, or other traumatic event, the medical examiner must be notified at once.

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ZIEGLER FUNERAL HOME  
FOR  
STATE HYNDMAN, PA 15545  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IRVIN AMBROSE DIEHL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/02/ 1985</b>		2b. HOUR <b>9:38 P</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04/13/1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		
						12b. KIND OF BUSINESS OR INDUSTRY <b>Auto Supply</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>PA</b>			13b. COUNTY <b>Somerset</b>		13c. CITY OR TOWN <b>Meyersdale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Frank Diehl</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula Ann Michaels</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>208091870</b>		17. INFORMANT ADDRESS <b>Dorothy L. Diehl, R D 4, Meyersdale, PA 15552</b>			

18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Diabetes; Old CVA</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Renato Espina</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <b>12/3/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RENATO ESPINA MD</b>		22e. ADDRESS <b>907 SETON DRIVE CUMBERLAND, MD 21502</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/6/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cooks Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RD, Hyndman, Somerset, PA</b>	
24. FUNERAL DIRECTOR <b>Harvey H. Zeigler, Hyndman, PA 15545</b>				25. DATE REC'D. BY REGISTRAR <b>DEC 9 1985</b>			
				26. REGISTRAR'S SIGNATURE <b>John H. ...</b>			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDMON YOUNG DILL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 12, 1985</b>			2b. HOUR <b>9:25 AM</b>				
3 SEX <b>male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01-03-1909</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ret. engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>		
13a. STATE <b>Md</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>22 Utah Avenue/21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest O. Dill</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa Belle Sensabaugh</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret A. Schaefer-Frederick, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Chronic Obstructive Lung Disease. Transitional cell Ca. of bladder</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12-11</b> , 19 <b>85</b> , to <b>12-12</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>12-12</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dr. Robustiano Barrera</b>						DEGREE		22c. DATE SIGNED <b>12-13-85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Robustiano Barrera</b>						22e. ADDRESS <b>Memorial Hospital Medical Bldg. Cumberland, MD 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-15-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>		
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, MD 21502</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John A. ...</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, who must be consulted at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. STATE REGISTRAR  
DECEASED NAME  
(TYPE OR PRINT)FIRST MIDDLE LAST  
SAMUEL Freeman DISHONG JR2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
DECEMBER 5 1985 6:10 AM3. SEX  
Male4. RACE  
White5. DATE OF BIRTH  
MONTH DAY YEAR  
Sept. 15, 19216. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.  
64 YRS. MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
PA7b. CITIZEN OF WHAT COUNTRY?  
USA8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH  
ALLEGANY COUNTY MD.10. CITY OR TOWN OF DEATH  
Cumberland11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
SACRED HEART HOSPITAL12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Manager12b. KIND OF BUSINESS OR INDUSTRY  
AutomobileUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS?  
Maryland Allegany Corrigansville YES ☐ NO ☒13e. STREET ADDRESS / ZIP CODE  
P.O. Box 236 / 2152414. FATHER'S NAME  
FIRST MIDDLE LAST  
Samuel F. Dishong, Sr15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
Marie Duckworth16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
Yes WW II16b. SOCIAL SECURITY NO.  
215-12-259817. INFORMANT ADDRESS  
Mrs. Sandra Robertson-Leadville, Colo.18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

A CUTE Respiratory Failure

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
2 WKSConditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic Obstructive Pulmonary Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from Jan 1975 to Dec 5 1985, that (I) (we) lost  
saw the deceased alive on Dec 4 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐22c. DATE SIGNED  
12/5/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

RICHARD SCHMITT, MD

900 SETON DRIVE, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION  
CITY OR TOWN COUNTY STATE

Burial

Dec. 7, 1985

Rest Lawn Mem. Gardens LaVale, Alleg., MD

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

John J. Hafer, Jr. LaVale, MD

DEC 9 1985

J. J. Hafer

ALBANY COUNTY

SACKED HEART HOSPITAL

CHAMBERLAND

P.O. Box 222, 1932

Albany County, New York

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Albany, New York

Albany, New York

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900 SETON DRIVE, MONTICELLO, N.Y.

RICHARD SCHWITZ

Dec. 7, 1932

John J. Schmitt, Jr., Albany, N.Y.



353059

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXAMINED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BASIS TO OBTAIN PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH: 17  
1VR A15 ME (5)  
15M 7/76

FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Linda Carol Ellifritz			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12 11 19 85			2b. HOUR 9:45 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 17 1951	6. AGE (IN YEARS) LAST BIRTHDAY 34 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 11 19 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co. MD.	
10. CITY OR TOWN OF DEATH Luke		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 114 Mullan Ave. Luke, Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Key Punch Oper.		12b. KIND OF BUSINESS OR INDUSTRY Said Inc.
13a. STATE Md.		13b. COUNTY Allegany	13c. CITY OR TOWN Luke	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21540 114 Mullan Ave Luke Md.		
14. FATHER'S NAME FIRST MIDDLE LAST Gerald Guy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joan Seaber				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-62-602		17. INFORMANT ADDRESS Fred Ellifritz Luke, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous Cell Carcinoma of</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <u>Larynx with metastasis.</u> (b) <u>Larynx with metastasis.</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE Francisco Reyes			TITLE (SPECIFY) Deputy MEDICAL EXAMINER			DATE SIGNED 12-11-85	
EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes			ADDRESS 900 Seton Dr. Cumberland, Md. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-14-85		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md
24. FUNERAL DIRECTOR Boal Funeral Service			ADDRESS Westernport Md.		25a. DATE REC'D. BY REGISTRAR DEC 16 1985		
			25b. REGISTRAR'S SIGNATURE Julia Davidson				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DURST FUNERAL HOME				STATE OF MARYLAND			
1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
2 E. MAIN ST FROSTBURG, MD 21532				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
MARIE AGNES FARRELL				DECEMBER 18, 1985			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		JAN. 2, 1907		78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL		TEACHER		SCHOOL	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		ALLEGANY		MT. SAVAGE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
ROBERT		FRANCES		# 3 C STREET, 21545			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		217 28 9756		EDWARD J. FARRELL, SAME AS 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Cardiac arrest possible New MI &amp; Myocardial infarction</i>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <i>Severe CAD &amp; previous MI</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <i>Hypertensive Cardiovascular disease</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Type II diabetes, controlled arteriosclerosis</i>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
				P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>11/5</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<i>[Signature]</i>				MD		<i>12/21/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
V.F. FELIPA				925 BISHOP WALSH DR. CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		DEC. 21 '85		ST. PATRICK CEM.		MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
DURST FUNERAL HOME, FROSTBURG, MD. 21532				DEC. 31 1985			
25b. REGISTRAR'S SIGNATURE							

BP

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

DECEMBER 18, 1955

MEMORANDUM

TO :

FROM :

TO :

DATE : 12.18.55

RE :

SUBJECT :

ALLEGED CRIME

U.S.A.

THOMAS

CAROL MARY HORTON

CONSPIRACY

5 30 HOURS, 1955

RE. HORTON

ALLEGED CRIME

1955

1955

1955

1955

1955

1955

1955

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/10/00 BY 60322

DATE 10/10/00 BY 60322

DATE 10/10/00 BY 60322

006122

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUSSELL ALVIN FLAKE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 22, 1985</b>		2b. HOUR 9:16 A M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01-30-1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Brewing Co.	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Flake		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavania Browning		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 218-16-2762		17. INFORMANT ADDRESS Mrs. Hazel P. Flake, Cumberland, MD - wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cardiogenic shock</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> 19 <u>85</u> , to <u>12/22</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/22</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William P. Iames</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/24/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM P. IAMES		22e. ADDRESS 441 N. CENTRE STREET, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-24-1985		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR DEC 27 1985		25b. REGISTRAR'S SIGNATURE <u>Julia F. ...</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, along with the death certificate, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

20% COTTON FIBER

347051

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES CLIFTON FLETCHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 5, 1985</b>		2b. HOUR <b>2:45 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCTOBER 12 1904</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED CELANESE</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>CORP. SILK</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MARYLAND</b> 13c. COUNTY <b>ALLEGANY</b> 13d. CITY OR TOWN <b>CUMBERLAND</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>COURTNEY A. FLETCHER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GRACE ADAMS</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-10-1515</b>		17. INFORMANT ADDRESS <b>ETHEL FLETCHER 1818 FREDERICK ST CUMBERLAND MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Asperter pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>CVA multiple recurrent</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <u>11-7-</u> 19 <u>85</u> , to <u>12-5-</u> 19 <u>85</u> , that (2) (we) last saw the deceased alive on <u>12-4-</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Anthony Bollino</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-5-85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Anthony Bollino</b>		22e. ADDRESS <b>955 Frederick Street Cumberland, MD 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>DEC 8 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL PARK</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND</b>				
25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1985</b>		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>				

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

100% COTTON FIBER

DAVID

WILSON





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

365171

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Agnes MARIE Frankland</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>12 17 85</b>		7b. HOUR <b>3:25 AM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 13 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>89</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Community Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN H. BOETTNER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY A. WHITEFIELD</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-16-2131</b>	
17. INFORMANT ADDRESS <b>ANNA CURL 3200 NORTH EAST 36th ST FORT LAUDERDALE FLORIDA</b>		18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute Gastro intestinal bleeding</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute Intestinal Obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>due to fecal impaction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Congestive heart failure (Anemia); old age. Renal failure.</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>12/9/85</b> to <b>12/17/85</b> , that (I) (we) last saw the deceased alive on <b>12/16/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <b>S. Lal Sandhir</b> DEGREE <b>MD</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Lal Sandhir, M.D.</b>		22d. ADDRESS <b>48 Tarn Terrace Frostburg, MD 21532</b>		22e. DATE SIGNED <b>12/17/85</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>DEC 20 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK CUMBERLAND ALLEGANY MARYLAND</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>SILCOX-MERRITT FUNERAL SERVICE</b>		ADDRESS <b>CUMBERLAND MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 4 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, or if the medicolegal examiner is notified at all, the medicolegal examiner must be notified at once.

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20% COTTON-KH-100



CHIEF-KH-100

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NEWMAN FUNERAL HOME  
1- STATE P.O. BOX 267  
REGISTRAR GRANTSVILLE, MD 21536  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROSE ANNA GARLITZ			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 29, 1985		2b. HOUR 8:10P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7/8/1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook	12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Maryland	13b. COUNTY Garrett	13c. CITY OR TOWN Grantsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Star Route, Box 150 21536	
14. FATHER'S NAME FIRST MIDDLE LAST Levi -- Garlitz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Mae Klink			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---		16b. SOCIAL SECURITY NO. 220-28-9885	17. INFORMANT Helen Edgar		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Rheumatoid Arthritis</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.					
22b. SIGNATURE <i>[Signature]</i> M.D.				22c. DATE SIGNED 12/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUSAN SCHWARTZ				22e. ADDRESS FROSTBURG PLAZA, RTS. 36 & 40 FROSTBURG, MD 21532	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 2, 1986	23c. NAME OF CEMETERY OR CREMATORY St Ann's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Avilton, Garrett, MD	
24. FUNERAL DIRECTOR NAME <i>[Signature]</i>		ADDRESS Grantsville, MD		25a. DATE REC'D. BY REGISTRAR JAN 7 1986	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

POST OFFICE BOX 321  
GRANVILLE, OH 43036

ROSE 01/10 04/10 05/10 06/10 07/10 08/10 09/10 10/10 11/10 12/10

ALBANY COUNTY

SACRED HEART HOSPITAL

440-28-9882



STANDARD SERVICE

POSTAGE WILL BE PAID BY ADDRESSEE  
FIRST CLASS PERMIT NO. 1000 COLUMBUS, OH

003003

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HOMBERT FUNERAL HOME				STATE OF MARYLAND			
FOR BOX 37 1- STATE REGISTRAR CONFLUENCE PA, 15424				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
REG. NO.				9:25 A			
1. DECEASED NAME (TYPE OR PRINT) WILMA LEATHERMAN GEORGE				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 28, 1985			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 23 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Pa.				13b. COUNTY Somerset		13c. CITY OR TOWN Addison	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick H Linkous				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret B Moore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-14-2672		17. INFORMANT ADDRESS Patricia Meyers Addison Pa. 15411			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pung Cancer Metastatic To Brain</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ENJOYING <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>12/28</u> 19 <u>85</u> to <u>12/28</u> 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>12/28</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we could not view the body after death, so state.)							
22b. SIGNATURE <u>Richard Schmitt</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/28/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD SCHMITT, MD				22e. ADDRESS 900 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 31, 85		23c. NAME OF CEMETERY OR CREMATORY Addison Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Addison Somerset Pa.	
24. FUNERAL DIRECTOR NAME <u>Wm. S. Schmitt</u>				ADDRESS CONFLUENCE, Pa.		25a. DATE REC'D. BY REGISTRAR JAN 2 1986	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DECEMBER 22, 1982

GEORGE

LEATHMAN

WILLY

70

Nov. 23 1915

white

Female

ALLERMAN GARY

x

U. S. A.

.a.

mm hons

honsville

SACRED HEART HOSPITAL

unberland

1511

x

addison

honsville

.a.

honsville

honsville

linxons

Frederick H

addison v. 1211

230-1-2075

to

200 SEVEN DRIVE, CHICAGO, IL 60612

RICHARD SCHULTZ, MD

addison honsville

addison honsville

Dec. 31, 82

trial



008141

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH			MONTH			DAY			YEAR			2b. HOUR													
William Irvin Gephart												12			30			1985																			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			IF UNDER 1 YR.			IF UNDER 24 HRS.			7c. DATE PRONOUNCED DEAD			2d. HOUR																
Male			Cau			7 1 04			81									12			30			1630													
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			WIDOWED			DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH																			
Md			USA															Allegany																			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK)			12b. KIND OF BUSINESS																												
Lonaconing			36 Church Street			Ret. Sup. Gen.			Textile																												
13a. STATE			13b. CITY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS																									
Maryland			Allegany			Lonaconing			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			36 Church Street			21639																						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																						
Harry			Mary			No			None			216-07-2731			Mrs. Elizabeth Gephart			36 Church St. Lonaconing, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1 DEATH WAS CAUSED BY:																																					
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest																		sudden																			
DUE TO, OR AS A CONSEQUENCE OF																																					
(b) Left ventricular heart failure																		months																			
DUE TO, OR AS A CONSEQUENCE OF																																					
(c) Coronary artery heart disease																		years																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																					
Gastric lymphoma																																					
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?													
12/21/85												Gastric biopsy, lymphoma												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS												21b. TIME OF INJURY												21c. HOW INJURY OCCURRED													
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												HOUR A.M. MONTH DAY YEAR												ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
												P.M. 19																									
21d. INJURY OCCURRED												21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)												21f. LOCATION													
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																								CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																					
ACTUAL SIGNATURE												TITLE (SPECIFY)												DATE SIGNED													
EXAMINER'S NAME												M.D. Dpty												MEDICAL EXAMINER													
Paul Snow, M.D.												Memorial Hospital, Cumberland Md												2150													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION	
Burial												1-1-86												Frostburg Mem. Park Frostburg Allegany Md												STATE	
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE													
Archorn Funeral Home, Lonaconing, Md.												JAN 6 1986												John Burdick-Rodette													



RECEIVED  
JAN 10 1963  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Mr. J. Edgar Hoover

Director

Washington, D.C.

Dear Sir:

Enclosed for you are

three copies of a letter

headquartered in New York

City, dated January 8, 1963.

The letter is being

forwarded to you for your

information and for your

comment.

Very truly yours,

W. J. Rorick

Special Agent in Charge

Deputy

240-07-2150

Mr. J. Edgar Hoover

Washington, D.C.

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364136

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

SCARPELLI FUNERAL HOME				STATE OF MARYLAND			
1 - STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
VIRGINIA AVE. CUMBERLAND, MD 21502				CERTIFICATE OF DEATH			
REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN VERNON GORDON				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 11, 1985		2b. HOUR 2:30 P.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 02-08-1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) COUNTY MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY n/a	
13a. STATE MD				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 129 Offutt Street 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Walter Gordon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Clark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT ADDRESS Mr. William Kenneth Gordon, Cumberland, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock 20 Pseudomonas</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Possible Cerebral infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 21</u> 19 <u>85</u> to <u>Dec 12</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>Dec 12</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Chang Oh</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHANG OH		22e. ADDRESS 48 TARN TERRACE FROSTBURG, MD 21532					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-13-1985		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE DEC 9 1985			

MEDICAL CERTIFICATION

324133

SCARFELL FURNACE WORKS  
VIRGINIA AVE  
CLEVELAND, OH 44115

JOHN

GORDON

DECEMBER 11, 1985

5:30 P

ALLEGANY COUNTY

SACRED HEART HOSPITAL



Handwritten notes and markings, including a large 'X' and various illegible scribbles.

4000 TERRY AVE  
CLEVELAND, OH 44115

CHANG ON

002175

1- FOR  
STATE  
REGISTRAR

P.O. 124

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

AUGUSTA WVA 26704 CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN ALFRED GROSS			2a DATE OF DEATH MONTH DAY YEAR DECEMBER 18, 1985		2b HOUR 7:15 A	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct 7, 1909		
6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.						
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		
12b KIND OF BUSINESS OR INDUSTRY Automobile		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS / ZIP CODE Route 50 26757		
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Gross		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Valentine		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b SOCIAL SECURITY NO. 232-54-2667		17 INFORMANT Johnny Gross		ADDRESS Romney, W. Va. 26757		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE DEGREE William W Mark Jr MD				22c. DATE SIGNED 19 Dec 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM MARK, MD				22e. ADDRESS 925 BISHOP WALSH DRIVE, CUMBERLAND, MD 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/20/85		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Romney Hampshire W. Va.		24 FUNERAL DIRECTOR NAME James R. Pyle		25a. DATE REC'D. BY REGISTRAR DEC 31 1985	
25b. REGISTRAR'S SIGNATURE John Davidson					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

BP  
999977  
DHMH - 16-20M 7/84  
(VRA 15. 4)

10-11-71

JOHN ALFRED ROSS

White

ALLBONY COUNTY

WATERBURY HOSPITAL

WATERBURY HOSPITAL

WATERBURY HOSPITAL

WATERBURY HOSPITAL

WATERBURY HOSPITAL

WATERBURY HOSPITAL

008112

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Emma Grunfelder		2a. DATE OF DEATH MONTH DAY YEAR 12 29 85		2b. HOUR 8:05 A.M.		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01-04-1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Uecker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna (nmn)			13e. STREET ADDRESS / ZIP CODE 1312 Michigan Avenue/21502				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 097-05-5927		17. INFORMANT ADDRESS Mrs. Ella M. Lagratta, Cumberland, MD-daughter					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>C.H.F., A.S.H.D.</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12-3</u> , 19 <u>85</u> , to <u>12-29</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>12-29</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>V.A. Ranjithan</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-30-85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.						22e. ADDRESS L.M.N.H. Seton Drive, Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-31-1985		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 2 1986 <u>John Davidson, Registrar</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Their plaque remains with the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

SHIRTS

THREE FIFTHS DOWN

20% COTTON FIBER



MADE IN AMERICA



364004

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>CARLETON W HANKS, JR</b>					2a. DATE OF DEATH MONTH <b>DEC</b> DAY <b>14</b> YEAR <b>1985</b>					2b. HOUR <b>1220HRS</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>JUNE</b> DAY <b>06</b> YEAR <b>1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL AND MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ret. pharmacist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>pharmacy</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>					13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Carleton W.</b> MIDDLE <b>H.</b> LAST <b>Hanks, Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Bessie A.</b> MIDDLE <b>S.</b> LAST <b>Spiker</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>MEMORIAL HOSPITAL</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neutrolan phillatin</b> DUE TO, OR AS A CONSEQUENCE OF <b>CAD.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF <b></b> (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> 19 <b>85</b> to <b>12/14</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>12/14</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Halamos</b>			DEGREE <b>MD</b>			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>12/14/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR PETER HALAMOS</b>			22e. ADDRESS <b>MEMORIAL MED BUILDING CUMB MD 21502</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-16-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Cumberland</b> COUNTY <b>Allegany</b> STATE <b>MD</b>				
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, MD 21502</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 18 1985</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>					

FOR  
STATE  
REGISTRAR

REG. NO.

DHMH - 16 60M 7/84  
(VRA 15, 4)

10-10-8

BOX COLUMN FIBER

CHIEF MAN BOARD



10-10-8

315142

DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PLESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Jeannette Marie Heagle		12-01 85		08:37A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
female	white	03 06 1948	37 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
GERMANY	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	ALLEGANY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	Sacred Heart Hospital	HOUSE WIFE			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Allegany	CUMBERLAND	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	315 MCGILL DRIVE 21502	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			
UNKNOWN	JADWIGA BARTCZAK	NO			
17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
MICHAEL HEAGLE 315 MCGILL DRIVE	PART I DEATH WAS CAUSED BY:				
	IMMEDIATE CAUSE (a) <u>Liver Cirrhosis, and possible</u>				
	DUE TO, OR AS A CONSEQUENCE OF				
	(b) <u>bleeding esophageal varices due to</u>				
	DUE TO, OR AS A CONSEQUENCE OF				
	(c) <u>chronic alcoholism.</u>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?			
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
		CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED			
Francisco Reyes	Deputy	12-1-85			
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS	23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			
Francisco Reyes	900 Seton Dr. Cumberland, Md	CREMATION			
23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION			
DEC 2 1985	rosedale crematory	CITY OR TOWN COUNTY STATE			
		MARTINSBURG BERKELEY W.VA. 21502			
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD	DEC 05 1985	Julia Davidson-Randall			

31213

Domestic Trade

12-01 22 08-31

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1000 00 00

003088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be modified or checked.

GEORGE UPCHURCH FUNERAL HOME STATE OF MARYLAND				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
1- FOR STATE REGISTRAR GREENE STREET CUMBERLAND, MD 21502				CERTIFICATE OF DEATH			
REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDITH FRANCES HELKER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 28, 1985</b>		2b. HOUR <b>10:30 A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 24, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>78</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Textile Dept-Amcelle Celanese</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>		13c. COUNTY <b>Allegany</b>		13d. CITY OR TOWN <b>Cumberland</b>		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick - Murray</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie - Dix</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>214-07-5657A</b>		17. INFORMANT ADDRESS <b>John Helker-Address same as #13 above.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GANGRENE OF BOWEL</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>MESENTERIC ARTERY OCCLUSION</b>							<b>36 hrs</b>
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 27, 1985</b> to <b>Dec 28, 1985</b> , that (I) (we) last saw the deceased alive on <b>Dec 28, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Paul Livengood MD</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12-28-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul Livengood, M.D.</b>				22e. ADDRESS <b>BMG 912 SETON DRIVE, CUMBERLAND MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-30-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland-Allegany Co.-MD.</b>	
24. FUNERAL DIRECTOR NAME <b>George-Upchurch Funeral Home, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1985</b>			
25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							
202 Greene Street-Cumberland, Maryland 21502							

9381  
MEMO 3000 2000  
000000

BRIDGE STREET  
CLIFFLAND 21502

BATH FLOWERS HIKER  
DECEMBER 22, 1962

10:50 A

ALBANY COUNTY

SACRED HEART HOSPITAL

THE 212 SETON DRIVE, CLIFFLAND 21502



364135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		SCARPELLI FUNERAL HOME		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		75 32825	
108 Virginia Ave Cumberland, MD 21502		CERTIFICATE OF DEATH		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Foster S. Helmick				2a. DATE OF DEATH MONTH DAY YEAR December 12, 1985				2b. HOUR 12:30A <sub>M</sub>	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 07-14-1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USa		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. engineer		12b. KIND OF BUSINESS OR INDUSTRY railroad	
13a. STATE Md		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1008 Oldtown Road/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Sherwood Helmick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Harper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 232032405		17. INFORMANT ADDRESS Mrs. Bridget Spielman-Hagerstown, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Parkinson's Disease - Acute Urinary Tract Infection - Organic Brain Syndrome</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> , 19 <u>85</u> , to <u>12/12/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/11/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Sl Sandhir MD</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/12/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sikander Sandhir, M.D.				22e. ADDRESS 48 Tam Terrace, Frostburg, MD 21532					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-13-1985		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR DEC 19 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			



30-182

3000 111 Street, Room 100  
1000 111 Street, Room 100  
1000 111 Street, Room 100

12:30 PM December 12, 1982

Allegany County

Barrow Point Hospital

330032402

49 Third Avenue, Providence, RI 02903

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elmer DEWEY Henderson			2a. DATE OF DEATH MONTH DAY YEAR 12-12-85			2b. HOUR 11:15am			
3. SEX male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 13 97		6. AGE (IN YEARS LAST BIRTHDAY) 88		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co. MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Allegany County Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED B&O RAILROAD TRAINMAN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 901 Queen City Towers 21502	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT A. HENDERSON				15. MOTHER'S MAIDEN NAME MIDDLE LAST MINNIE McBRIDE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 705-09-7899		17. INFORMANT ADDRESS LILBURN HENDERSON BOX 35 GREENSPRING W.VA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Metastatic of the lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a A.S.C.V.D. Bilateral carotid disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-3, 1984, to 12-12, 1985, that (I) (we) lost saw the deceased alive on 12-12-85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE V.A. Ranjithan					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-12-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIMALA V. A. RANJITHAN					22e. ADDRESS 906 Weires Ave., LaVale, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC 14 1985		23c. NAME OF CEMETERY OR CREMATORY FOREST GLEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE GREENSPRING HAMPSHIRE W.VA.		
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MARY					25a. DATE REC'D. BY REGISTRAR DEC 16 1985				
					25b. REGISTRAR'S SIGNATURE Julia Swisher				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 there is any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EMMA JOSEPHINE HERNDON			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 19, 1985		2b. HOUR 10:35AM				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-16-1926		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD		13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William Clinton Knight		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Wickline		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 235-36-1040		17. INFORMANT ADDRESS Mrs. Arnett D. Herndon, Oldtown, MD - wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 months</u> <u>10 days</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-9</u> 19 <u>85</u> , to <u>12-19</u> 19 <u>85</u> , that (we) last saw the deceased alive on <u>12-8</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>William Lamm MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/19/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. LAMM						22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-22-1985		23c. NAME OF CEMETERY OR CREMATORY Oldtown Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Oldtown Allegany MD		
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR DEC 23 1985		25b. REGISTRAR'S SIGNATURE <u>John L. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director. Page 3 should be detached for use at the burial-transit permit. Then please remove carbon pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, medical condition, or other condition.

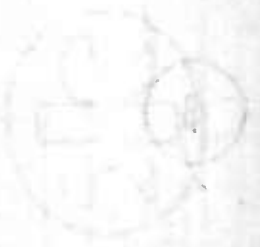
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HOWARD CLAY HETRICK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 19, 1985</b>		2b. HOUR <b>2:50</b> P M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2/10/1913</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		7. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD		10. CITY OR TOWN OF DEATH <b>Cumberland</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS DURING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction Wker Roads</b>		
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Garrett</b>		13c. STREET ADDRESS / ZIP CODE <b>Star Route, Box 35F 21536</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph -- Hetrick</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Armenta -- Butler</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>201-01-8086</b>		17. INFORMANT ADDRESS <b>Star Route, Box 35F Grantsville, MD 21536</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>C.V.A. (Cerebral Vascular Accident)</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Anderson</b> <b>u</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>N/A</b>						
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>November</b> , 19 <b>1985</b> , to <b>Dec 19</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>Dec 19, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Howard S. Diener</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/19/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Diener</b>		22e. ADDRESS <b>500 Memorial Ave., Memorial Med. Bldg. Cumberland, MD 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/22/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grantsville Cemetery</b>		
23d. LOCATION <b>Grantsville, Garrett</b>		23e. DATE REC'D. BY REGISTRAR <b>DEC 30 1985</b>				
24. FUNERAL DIRECTOR <b>J. Simon Newman</b>		ADDRESS <b>Grantsville, MD</b>		25a. REGISTRAR'S SIGNATURE <b>Alfred B. Baker</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and signed.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG NO

1. DECEASED NAME (TYPE OR PRINT)		FIRST JACKSON THOMAS		LAST HICKLE		2a. DATE OF DEATH MONTH DAY YEAR December 6, 1985		2b. HOUR P 2:00 M	
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 28, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland						13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST Thomas MIDDLE LAST Hickley						15. MOTHER'S MAIDEN NAME FIRST Amanda MIDDLE LAST Watts			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 705-10-5126		17. INFORMANT Mary K. Burris		ADDRESS 7608 Lancaster Road Little Rock, Arkansas			
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypoxia encephalopathy DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent seizures + Asphyxia Pneumonia R Lung CAD Organic Brain Syndrome									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that on (this hospital) attended the deceased from 12/6/85 to 12/6/85, that (we) last saw the deceased alive on 12/6/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (did) (did not) view the body after death.									
22b. SIGNATURE Shawn Nathan		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/6/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Nathan		22e. ADDRESS Medical Building Memorial Hospital Cumberland, Md. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/9/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN STATE Anne Arundel Maryland			
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR DEC 9 1985		25b. REGISTRAR'S SIGNATURE [Signature]					
230 Baltimore Ave. Cumberland, MD 21502									

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15.4) 1/791- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Nellie G. Hockman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 27 85</b>			2b. HOUR <b>5 15 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 16, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Village Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Practical Nurse</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elwood Crabtree</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Platt</b>			13e. STREET ADDRESS <b>114 South Smallwood St. 21502</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-05-5002</b>		17. INFORMANT ADDRESS <b>Mr. Edwin L. Hockman, Annandale Va.-Son</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHF, pacemaker insertion</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA - Rt. Hemisphere, Aphasia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 21 1979</b> to <b>Dec 27 1985</b> , that (I) (we) last saw the deceased alive on <b>Dec 27 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Shin E. Kim MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Shin E. KIM MD</b>			22e. ADDRESS <b>90 main St. Westport md 21562</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-30-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sulphur Springs Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Near Oldtown, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli</b>			ADDRESS <b>Cumberland, Md. 21502</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Lelia Fisher</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold K Hollada			2a. DATE OF DEATH MONTH DAY YEAR 12/21/85		2b. HOUR 12:10a M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1 23 30		
6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co MD.		
10. CITY OR TOWN OF DEATH Frostburg, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE Star Rt 1, 21536		13b. CITY OR TOWN Grantsville		
13c. COUNTY Garrett		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Star Rt 1, Box 170		
14. FATHER'S NAME FIRST MIDDLE LAST Russell -- Hollada		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary -- Folk		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17. INFORMANT Miss Terry Hollada		17. ADDRESS Route 1, Box 170		
17. ADDRESS Meyersdale, PA 15552		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIAC ARRYTHMIAS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>THEOPHYLLINE TOXICITY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ARTERIOSCLEROTIC HEART DISEASE CHRONIC OBSTRUCTIVE LUNG DISEASE</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> , 19 <u>85</u> , to <u>12/21</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>S. Chang</u> M.D.		
22c. DATE SIGNED 12/21/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Chang		22e. ADDRESS Hecks Plaza, Frostburg, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/85		23c. NAME OF CEMETERY OR CREMATORY Maple Glen Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Fort Hill, Somerset, PA		24. FUNERAL DIRECTOR NAME <u>D. Lynn Newman</u>		25a. DATE REC'D. BY REGISTRAR DEC 30 1985		
25b. REGISTRAR'S SIGNATURE <u>J. L. ...</u>		25c. ADDRESS Grantsville, MD		25d. ADDRESS Grantsville, MD		

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial transit permit. Then please return pages 3 and 4 to the funeral director. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial. A cremation permit may be obtained from the State Department of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page B should be detached for use as the burial-transit permit. Then please remove the certificate from this folder. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BOAL'S FUNERAL HOME

STATE OF MARYLAND

1- FOR MAIN ST. Item 18a+b, 1-25-86at DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
STATE REGISTRAR LONA CONING, MD 21539 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>AMANDA MAE HUGHES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/04/1985</b>		2b. HOUR M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>03/31/1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Silk Mill</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Material</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Lonaconing</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>21 Charlestown St. 21539</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bruce Coleman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabell Johnson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213-24-7388</b>		17. INFORMANT ADDRESS <b>Mr. Frederick Hughes Lonaconing, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b> <b>2 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. DONALD MANGER</b>		22e. ADDRESS <b>55 JACKSON ST. LONA CONING, MD 21539</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12/7/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Barton Allegany Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Boals Funeral Service</b>		Lonaconing, Md. 21539		25a. DATE REC'D. BY REGISTRAR <b>DEC 11 1985</b>	
				25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Fitch Imes		2a. DATE KNOWN OF DEATH 12 9 1985		2b. HOUR 0900	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 3 24 1908	6. AGE (IN YEARS) 77 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 12 9 1985
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Country Club			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 1 Box 19 Flintstone		12. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. CITY OR TOWN Allegany		13c. CITY OR TOWN Flintstone	
14. FATHER'S NAME Albert		15. MOTHER'S MAIDEN NAME Sadie Somerville		16. SOCIAL SECURITY NO. 213-12-9142	
17. INFORMANT Leah Swick - Keyser, W. VA.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Dpty MEDICAL EXAMINER		DATE SIGNED 12-9-85	
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D.		ADDRESS Memorial Hospital, Cumberland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/12/85		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		24b. ADDRESS LaVale, MD		25a. DATE REC'D. BY REGISTRAR DEC 13 1985	
25b. REGISTRAR'S SIGNATURE 					

3-13-73

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST ERMA		MIDDLE MAXINE		LAST JOHNSON		2b. DATE OF DEATH MONTH DAY YEAR December 5, 1985		2c. HOUR P. 8:15 M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB 1 1926		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD							
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RECP. AND BOOKKEEPER		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MARYLAND				13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1100 BEDFORD STREET 21502			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM R. E. SMITH				15. MOTHER'S MAIDEN NAME MIDDLE LAST HILDA R. VALENTINE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-22-6430		17. INFORMANT ADDRESS IRVIN JOHNSON 1100 BEDFORD ST CUMBERLAND MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Electrovent dissociation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute MI</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCVD</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <u>12-5</u> 19 <u>85</u> , to <u>12-5</u> 19 <u>85</u> , that (we) last saw the deceased alive on <u>12-5</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did not view the body after death.													
22b. SIGNATURE <u>Dr. A. Bollino</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>6 Dec 85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Bollino				22e. ADDRESS 955 Frederick Street Cumberland, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 8 1985		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND							
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MARYLAND				25a. DATE REC'D. BY REGISTRAR DEC 10 1985		25b. REGISTRAR'S SIGNATURE <u>J. L. ...</u>							

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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U. S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



Caroline Barrett  
Charlotte, N. C.  
June 17

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Washington, D. C.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) ROBERT LYNN KARLOWA			2a DATE OF DEATH MONTH DAY YEAR December 30, 1985		2b HOUR 10:00 p.m.						
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JUNE 4 1952		6 AGE (IN YEARS LAST BIRTHDAY) 33 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD					
10 CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BURTONS MENS STORE		12b KIND OF BUSINESS OR INDUSTRY -----			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 218 SCHLEY STREET 21502			
14 FATHER'S NAME FIRST MIDDLE LAST ROBERT HENRY KARLOWA				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BURTON							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-64-9136		17 INFORMANT ADDRESS ROBERT H. KARLOWA 218 SCHLEY STREET CUMBERLAND					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>States epileptic</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe A-V malformation</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arterio cranial stenosis</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>12/24</u> , 19 <u>85</u> , to <u>12/30</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Dr. William Iames</u>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 1/1/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William Iames				22e ADDRESS 441 N. Centre Street Cumberland, MD 21502							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE JAN 2 1986		23c NAME OF CEMETERY OR CREMATORY ST MICHAELS CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MARYLAND			
24 FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND						25a DATE RECD. BY REGISTRAR JAN 7 1986		25b REGISTRAR'S SIGNATURE <u>Juha Davidson-Randall</u>			

MEDICAL CERTIFICATION

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

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FOR STATE REGISTRAR				STATE OF MARYLAND				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 3 2 0 3 0			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR							
Agnes Louise Kiddy				December 7, 1985				8:30p M							
2. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
Female		White		4/25 1923		62									
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Westernport		USA				Allegany County, MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		Sacred Heart Hospital				Med. Records		Hospital							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
Maryland		Garrett		Oakland				703 Mitchell Drive 21550							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Charles S Dayton				Ethel Green											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS											
yes		WWII		219145834				Mrs. Glenda Newcomb Oakland, Md. 21550							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Metastasis.															
DUE TO, OR AS A CONSEQUENCE OF (b) ca of breast = Met.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 11-12, 1985, to 12-7, 1985, that (I) (we) last saw the deceased alive on 12-7, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				22c. DATE SIGNED							
John Mehanna, M.D.				M.D.				12-8-85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
John Mehanna, M.D.				909-B Seton Drive, Cumberland, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		10-11-85		Philos Cemetery				Westernport Allegany Md.							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Boals Funeral Service Westernport, Md. 21562				DEC 13 1985				John Mehanna							

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRMA M. KLINE			2a. DATE OF DEATH MONTH DAY YEAR Dec. 29, 1985		2b. HOUR 11:20 <sup>a</sup> M	
3 SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 03-28-1916		
6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD				
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) former employee		
12b. KIND OF BUSINESS OR INDUSTRY textile		13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland				
14 FATHER'S NAME FIRST MIDDLE LAST Matthew Andrews		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy May George				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-6342		17. INFORMANT ADDRESS Mr. Maynard O. Kline, Cumberland, MD - husband		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Anti Boreal fisher Tray to sepsis, cellulitis of both legs, Diabetes.</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Dr. R. Barrera</u>		DEGREE N.A. Registrar MD		22c. DATE SIGNED 12/29/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. R. Barrera		22e. ADDRESS The Memorial Hospital Medical Building Memorial Ave., Cumberland, Md. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-2-1986		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		24 FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				
25a. DATE REC'D. BY REGISTRAR JAN 2 1986		25b. REGISTRAR'S SIGNATURE <u>John Barrera</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. The placard for the funeral home or funeral home, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or a traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELDEN CLYDE LANDIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 7, 1985</b>		2b. HOUR <b>1:50P M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 2, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist-Helper Chessie Sy.</b>	
13a. STATE <b>W.Va.</b>		13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Keyser</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clyde - Landis</b>		15. MOTHER'S MIDDLE NAME FIRST MIDDLE LAST <b>Anna - Friend</b>		16. SOCIAL SECURITY NO. <b>219-16-9694</b>			
17. INFORMANT ADDRESS <b>Keyser, W. Va.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced Metastatic Ca.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Primary unknown.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.							
22b. SIGNATURE <b>Qamar Zaman</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/8/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>QAMAR ZAMAN</b>		22e. ADDRESS <b>MEMORIAL MEDICAL BLDG. CUMBERLAND, MD 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10 Dec 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Keyser Mineral W. Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Allen Rotruck</b>		ADDRESS <b>Keyser, W.Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 12 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John D. ...</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

35-2008

3814-10-1105-2008

ELDER CLYDE LANDIS DECEMBER 7, 1905 1:50P

Male White July 2, 1925

Maryland U.S.A. ALLEGANY COUNTY

Cumberlands SACRED HEART HOSPITAL

W.Va. Mineral Keyser 333 St. Clair St. 21070

Clyde - Anna - Friend

no 210-16-0000 Anna B. Landis 333 St. Clair St. Keyser, W. Va.

WESTERN MEDICAL BLDG.  
CUMBERLAND, MD 21501

OWEN DAVIS

Emilia 10 Dec 1925 St. Thomas Keyser Mineral W. Va.

Allen Horvick Keyser, W. Va. JUL 12 1985



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN JOSEPH LAUGHLIN</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 1 85</b>		2b. HOUR M <b>1847</b>
3. SEX <b>Male</b>	4. RACE <b>Cau</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9/18/1918</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>67</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.
10. CITY OR TOWN OF DEATH <b>Westernport</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>402 Maryland Ave</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Counselor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Westernport</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>402 Maryland Ave 21562</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John A. Laughlin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Hohing</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW2</b>	17. INFORMANT ADDRESS <b>Mrs. Barbara Beattie Beattie Cumberland, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Cardiac arrest</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
IMMEDIATE CAUSE (a): DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Coronary artery heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)				6 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that the charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Paul Snow, M.D.</b>		TITLE (SPECIFY) <b>Dpty</b>		DATE SIGNED <b>12/2/85</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Paul Snow, M.D.</b>		ADDRESS <b>Memorial Hospital, Cumberland Md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12/5/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westernport Allegany Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Boals Funeral Service</b> ADDRESS <b>Westernport, Md. 21562</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1985</b> 25b. REGISTRAR'S SIGNATURE <b>John A. ...</b>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST  
DOROTHY LOUISE LEE  
2a. DATE OF DEATH MONTH DAY YEAR  
December 6, 1985  
2b. HOUR  
10:15 P.M.

3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR  
Aug 14 1924  
6. AGE (IN YEARS LAST BIRTHDAY) 61  
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  
7b. CITIZEN OF WHAT COUNTRY? USA  
8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐  
9. BALTIMORE CITY OR COUNTY OF DEATH  
Allegany MD.

10. CITY OR TOWN OF DEATH  
Cumberland  
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Memorial Hospital  
12a. USUAL OCCUPATION  
(LAST OF WORK FOR MOST OF WORKING LIFE)  
Housewife  
12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE Pa 13b. COUNTY Somerset 13c. CITY OR TOWN  
13d. INSIDE CITY LIMITS? YES ☐ NO ☒  
13e. STREET ADDRESS / ZIP CODE  
RD 3 Meyersdale 15552

14. FATHER'S NAME FIRST MIDDLE LAST  
George W. Taylor  
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Marie Ryan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
No  
16b. SOCIAL SECURITY NO.  
200-14-7433  
17. INFORMANT ADDRESS  
Harry F. Lee RD 3 Meyersdale, Pa. 15552

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a) HEPATIC COMA  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Chronic Injurious Hepatitis  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I  
Chronic Renal Failure, Sicca Syndrome

19a. DATE OF OPERATION  
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
20a. AUTOPSY YES ☐ NO ☐  
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)  
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐  
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE  
Dr. Ranjithan  
22c. PHYSICIAN'S NAME (TYPE OR PRINT)  
22d. ADDRESS  
Memorial Hospital Medical Building  
Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial  
23b. DATE  
12/9/85  
23c. NAME OF CEMETERY OR CREMATORY  
Union Cemetery  
23d. LOCATION CITY OR TOWN COUNTY STATE  
Meyersdale Somerset Pa.

24. FUNERAL DIRECTOR NAME  
Leckemby Funeral Home  
25a. DATE REC'D. BY REGISTRAR  
25b. REGISTRAR'S SIGNATURE  
Julia Davidson-Rodriguez

26. MEDICAL CERTIFICATION  
MEDICAL CERTIFICATION  
MEDICAL CERTIFICATION

27. MEDICAL CERTIFICATION  
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28. MEDICAL CERTIFICATION  
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MEDICAL CERTIFICATION

29. MEDICAL CERTIFICATION  
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MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed.

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DDMM - 16 60M 7/B4  
(VRA 15, 4)

Female  
Maryland

White  
USA

Age 18  
X

61

Housewife

Somebody

Pa

George  
W. Taylor

Marie

RD 3 Maryland 15552

Ryan

No

Harry W. Lee RD 3 Maryland, Pa. 15552



Isokenby Funeral Home, Maryland, Pa. 15552  
Union Cemetery  
12/9/85  
Burial  
Maryland 15552  
Somebody

352144

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN GEORGE LESTER, JR.			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 7, 1985		2b. HOUR 3:20A M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 14 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED B & O RAILROAD		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 208 POLK STREET 21502	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN G. LESTER SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH BEATTY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS EVELYN LESTER 208 POLK ST CUMBERLAND MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> 19 <u>85</u> to <u>12/7</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/6</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. William P. Iames</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/7/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM P. IAMES				22e. ADDRESS 441 N. CENTRE ST. CUMBERLAND, MARYLAND 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 9 1985		23c. NAME OF CEMETERY OR CREMATORY REST LAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE LAVALE ALLEGANY MARYLAND			
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND				25a. DATE REC'D. BY REGISTRAR DEC 10 1985					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other physical event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please immediately file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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2000 COTTON FIBER

WILKINSON



002176

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LUCY Virginia LYONS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 18, 1985</b>		2b. HOUR <b>5:25 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 28, 1908</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		7. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital &amp; Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>						
13a. STATE <b>W.Va.</b>		13b. COUNTY <b>Grant</b>		13c. CITY OR TOWN <b>Maysville</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lyda Schell</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>234-70-1310-A</b>		17. INFORMANT ADDRESS <b>Robert Lyon Rt. #2 Box 62 Maysville, W.Va.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>general arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>enlarged colon, free R lip</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 11 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>No history available</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Maysville, W.Va.</b>		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (and) (did not) view the body after death.						
22b. SIGNATURE <b>Robert Feddis</b>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Robert Feddis</b>				22e. ADDRESS <b>925 Seton Drive Cumberland, MD 21502</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/21/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>So. Branch Mem. Gar.</b>		
23d. LOCATION CITY OR TOWN <b>Petersburg, W.Va.</b>		23e. STATE <b>26047</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Arnold-Basagic Funeral Home Petersburg, W.Va.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1985</b>		
				25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SCOTT</b>			FIRST MIDDLE LAST <b>MAC MILLAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 13 1985</b>			2b. HOUR <b>11 45 P.M.</b>		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 14, 1901</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CUMBERLAND NURSING &amp; CONVALESCENT CENTER</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ENGINEERING</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>TEXTILE</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>CUMBERLAND</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ADAM MAC MILLAN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARTHA LEE</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-07-1897</b>		
17. INFORMANT ADDRESS <b>AGNES SMITH, CUMBERLAND, MD.</b>											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Hypoxia**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Co PD.**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>P. HALLOS</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/14/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. HALLOS</b>		22e. ADDRESS <b>302 Schley St. Cumberland, Md.</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>DEC. 14, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LONA CONING, MD.</b>	
24. FUNERAL DIRECTOR NAME <b>PURST FUNERAL HOME, FROSTBOURG, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 23 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Swindon Bondell</b>			

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LABORATORY OF  
PHYSICS  
UNIVERSITY OF CALIFORNIA  
BERKELEY, CALIF.

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed purchase of the land for the proposed site of the new building for the Laboratory of Physics.  
I am sorry that I am unable to give you a more definite answer at this time, but the matter is being considered by the Board of Regents and the Board of Trustees of the University of California.  
I am sure that you will understand the necessity for this delay.  
Very truly yours,  
[Signature]



364025

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have it filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked, item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Margaret Virginia Markley					2a. DATE OF DEATH MONTH DAY YEAR 12 11 85			2b. HOUR 11:12am	
3. SEX female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 27 22		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Allegany Co. Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Furnace St. Extd. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Linburn Smith Blackburn					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Peyton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 234269720		17. INFORMANT ADDRESS Mr. Galen E. Markley Short Gap, W.Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe C.O.P.D. DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Corr - Pulmonary									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-17, 1985, to 12-11, 1985, that (I) (we) lost saw the deceased alive on 12-11, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE V.A. Ranjithan				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-11-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIMALA A. RANJITHAN				22e. ADDRESS 906 Weires Ave., LaVale, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 14, 1985		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md.			
24. FUNERAL DIRECTOR Markwood-McKenzie Funeral Home				ADDRESS 111 S. Mineral Keyser, W.Va.		25. DATE RECEIVED BY REGISTRAR DEC 18 1985			

BP.

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10-10-50

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FOR NATIONAL HWG  
1 - STATE REGISTRAR LAVALE, MD 21502

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (Last, first, middle) VIVIAN LUCILLE MATHENY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 5, 1985		2b. HOUR 11:15AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 / 27 / 1907		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Effinger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adeline Davis		13d. STREET ADDRESS / ZIP CODE 609 Cumberland Arms/21502		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-34-1399		17. INFORMANT Ann Strieby - LaVale, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO, OR AS A CONSEQUENCE OF b) <u>ABHD, atrial fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>5 years</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Heart failure, renal failure</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>George Breza MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/5/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Breza MD		22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/06/85		23c. NAME OF CEMETERY OR CREMATORY Smithburg Crematory		
23d. LOCATION CITY OR TOWN COUNTY STATE Smithburg, Washing., MD						
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, MD		25a. DATE REC'D. BY REGISTRAR DEC 11 1985		
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and confirmed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

317018

NATIONAL MAY  
LAVALLE, MD 21502

VIVIAN LUCILLE WATSON

DECEMBER 2, 1985

11:25AM

ALLIANCE COUNTY  
USA

X

SACRED HEART HOSPITAL

LAVALLE, MD 21502

X

FREDERICK

1200-12-1-1985 - LAVALLE, MD

LAVALLE, MD

LAVALLE, MD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and given a copy of this certificate.

## MEDICAL CERTIFICATION

George-Upchurch Funeral Home, STATE OF MARYLAND				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 5 3 2 8 4 6			
1. FOR STATE REGISTRAR 202 Greene Street Cumberland, MD 21502				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Elizabeth Mauk				2a. DATE OF DEATH MONTH DAY YEAR December 30, 1985				2b. HOUR 10:40 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 11, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE West Va.				13b. COUNTY Mineral		13c. CITY OR TOWN Ft. Ashby		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Box 349 / 26719 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Charles L. Dowden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frashier - Burkett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -				16b. SOCIAL SECURITY NO. 235822590		17. INFORMANT ADDRESS Phyllis Malone - Wiley Ford, West Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Multiple infarction in terminal state DUE TO, OR AS A CONSEQUENCE OF (c) Paroxysmal pneumonia, severe APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-10, 1985, to 12-10-1985, that (I) (we) lost saw the deceased alive on 12-10, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John Mehanna, M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-31-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Mehanna, M.D.				22e. ADDRESS 909-B Seton Drive, Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-2-86		23c. NAME OF CEMETERY OR CREMATORY Ft. Ashby Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Ashby - Mineral - West Va.			
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE HAN 6 1986			



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General Hospital  
302 Second Street  
Cleveland, OH 43102

10:00

November 30, 1982

Alfred J. Smith

Mr.

Alfred J. Smith

General Hospital

000000

22-11-1982

11-11-1982

11-11-1982

11-11-1982

002-4 Second Street, Cleveland, OH 43102

002-4 Second Street

002-4

351115

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-100. RETURN PAGE 5 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH <del>xx</del> MONTH DAY YEAR 12 10 1985										2b. HOUR 1:50a			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert L. McKenzie										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 10 1985										2d. HOUR 1:50a			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1900		6. AGE IN YEARS (AT BIRTHDAY) YRS. 85		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.											
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian				12b. KIND OF BUSINESS SCHOOL							
13a. STATE Ma										13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 454 21532							
14. FATHER'S NAME Leo Wm. McKenzie										15. MOTHER'S MAIDEN NAME Hanora Coleman													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE DATES) None 212-12-8236				17. INFORMANT ADDRESS Mary Monroe Rt. 1, Box 454, Frostburg Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Giovanni Mastrangelo				TITLE (SPECIFY) M.D. DEAO-4				MEDICAL EXAMINER				DATE SIGNED 12/10/85											
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D.				ADDRESS 900 Seton Drive, Cumberland, MD 21502																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 13, 1985				23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Midland Allegany Md											
24. FUNERAL DIRECTOR L. E. Lohhorn Funeral Home, Lonaconing, Md.										25a. DATE REC'D. BY REGISTRAR DEC 13 1985				25b. REGISTRAR'S SIGNATURE									

36-58585-1

364008

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
ROY LELAND MERRITT		December 13, 1985		11:10p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
male	white	MONTH DAY YEAR	81 YRS.	Allegany MD.	
7b. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MD	USA		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital		retired grocer		grocery store
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
MD		Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		Valley Road-Forest Drive/21502	
William F. Merritt		Bessie E. Daniels			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		212-24-1296		Roy & Charles Merritt, Cumberland, MD - sons	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE					
DUE TO, OR AS A CONSEQUENCE OF					
(b) ACUTE MYOCARDIAL INFARCTION					
DUE TO, OR AS A CONSEQUENCE OF					
(c) CONGESTIVE HEART FAILURE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
DIABETES MELLITUS.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHEEL <input type="checkbox"/> NOT WHEEL <input type="checkbox"/> AT WHEEL <input type="checkbox"/> AT WHEEL <input type="checkbox"/>		LAX, HOME, STREET, FACTORY, OFFICE, PARK, ETC.		CITY OR TOWN COUNTY STATE	
21g. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost					
saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22a. SIGNATURE					
DEGREE					
22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (TYPE OR PRINT)					
Dr. A. Torres					
22d. ADDRESS					
Memorial Hospital Medical Building					
Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
(SPECIFY)		12-16-1985		St. Lukes Cemetery	
Burial				Cumberland Allegany MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
James F. Scarpelli, Cumberland, Md 21502					

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DEC 18 1985

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

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364166

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>TRUMAN LESLEY MICHAELS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 16, 1985</b>		2b. HOUR <b>1:00A.M.</b>
3 SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1/12/1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sawmiller</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Garrett</b>	13c. CITY OR TOWN <b>Friendsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Route 1, Box 149 21531</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Victor - Michaels</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Esta - VanSickle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-18-9891</b>		17. INFORMANT ADDRESS <b>Route 1, Box 149</b> <b>Mrs. Goldie P. Michaels Friendsville, MD 21531</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GRAM NEGATIVE SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LVL PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>LYMPHOMA</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>IMMUNE SUPPRESSION 2° TO #C</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <i>[Signature]</i>		DEGREE <b>MD</b>		22b. DATE SIGNED <b>10/16/85</b>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. RAVER</b>		22c. <b>MEMORIAL HOSPITAL MEDICAL BUILDING</b> <b>CUMBERLAND, MARYLAND 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>	23b. DATE <b>12/18/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sand Spring Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Friendsville, Garrett, MD</b>	
24. FUNERAL DIRECTOR <i>[Signature]</i> <b>Grantsville, MD</b>		25. DATE RECD. BY REGISTRAR <b>DEC 23 1985</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it will completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

304100

Handwritten text, likely a letter or document, written in cursive script. The text is faint and mostly illegible due to fading and bleed-through from the reverse side. Some words are difficult to decipher but appear to include "Dear Sir", "I have the honor", "to acknowledge", "the receipt of", "your letter of", "the 10th inst.", "and in reply to", "inform you that", "the same has been", "forwarded to the", "proper authorities", "for their consideration.", "Very respectfully", "Yours, Sir, Obedient Servant", "J. M. Smith".



353034

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Clarence E. Miller</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 11, 1985</b>			2b. HOUR M <b>AM</b>				
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 2, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>140 E. Main Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pipefitter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tire Co.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>140 E. Main St., 21532</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William T. Miller</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jessie Waddell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214-07-57074</b>		17. INFORMANT ADDRESS <b>Catherine Miller, Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma of the prostate</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Atherosclerosis Cardiovascular Disease</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Susan Schwartz, M.D.</b>						DEGREE M.D.		22c. DATE SIGNED <b>12/12/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Susan Schwartz, M.D.</b>						22e. ADDRESS <b>Frostburg Plaza, Frostburg, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 14 '85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Eckhart, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Durst Funeral Home, Frostburg, Md.</b>						25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>DEC 16 1985</b>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edgar H Miller			2a. DATE OF DEATH MONTH DAY YEAR 12/28/85		2b. HOUR 9:02a M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 8/02/ 11	6. AGE (IN YEARS LAST BIRTHDAY) 74	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Frostburg, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md	13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 61 Broadway 21532	
14. FATHER'S NAME FIRST MIDDLE LAST HARVEY MILLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALBERTA STEVENSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A.	17. INFORMANT FROSTBURG, MD 21532 MRS. EDGAR MILLER, 61 BROADWAY,			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Jesse H. Tan		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. Tan		22e. ADDRESS Frostburg Plaza, Frostburg, Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/31/85	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK	23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD
24. FUNERAL DIRECTOR Sowers Funeral Home 60 W. MAIN ST. Main St., Frostburg, Md		25a. DATE REC'D. BY REGISTRAR JAN 9 1986	25b. REGISTRAR'S SIGNATURE Lelia Davidson-Pondell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the signature of the funeral director from page 3 and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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STATION

NO. 1000  
MILWAUKEE  
WISCONSIN  
JAN 2 1968



JAN 2 1968  
MILWAUKEE  
WISCONSIN

347002

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 8 5 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MCCLELLAN HARRY MORGRET			2a. DATE OF DEATH MONTH DAY YEAR 12 05 85			2b. HOUR 10:03A M				
3 SEX MALE		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06 09 01		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD				
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Road Dept.		12b. KIND OF BUSINESS OR INDUSTRY County		
13a. STATE W. VIRGINIA			13b. COUNTY Mineral		13c. CITY OR TOWN RIDGELEY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE PO BOX 80 26755 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Morgret				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha True						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-10-2212		17 INFORMANT ADDRESS Mr. Paul A. Morgret, Ridgeley, WV - son					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR TACHYCARDIA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>Vasculitis Day to Day, CHF, Sx</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Ranjithan</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/6/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RANJITHAN				22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-08-1985		23c. NAME OF CEMETERY OR CREMATORY Piney Plains Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Flintstone Allegany MD			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR DEC 9 1985		25b. REGISTRAR'S SIGNATURE <u>John L. ...</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

217005

20% COLLOIDAL FIBRE

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please review our cartoon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

|  |  |  |           |   |                                  |   |          |   |                                   |  |  |                                |  |
|--|--|--|-----------|---|----------------------------------|---|----------|---|-----------------------------------|--|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  | MIDDLE    | LAST  | 2a. DATE OF DEATH MONTH DAY YEAR |   | 2b. HOUR |   |                                   |  |  |                                |  |
|  |  | RUTH   | ELIZABETH | NINER   | DECEMBER 12, 1985                |   | 9:50 AM  |   |                                   |  |  |                                |  |
| 3. SEX   |  | 4. RACE  |           | 5. DATE OF BIRTH MONTH DAY YEAR   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.  |          | IF UNDER 1 YEAR MONTHS DAYS   |                                   | IF UNDER 24 HRS. HOURS MIN.                  |  |                                |  |
| FEMALE   |  | WHITE  |           | JUNE 18, 1919   |                                  | 66  |          |   |                                   |  |  |                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |          |   |                                   |  |  |                                |  |
| MARYLAND   |  | U.S.A.   |           |   |                                  | ALLEGANY COUNTY MD  |          |   |                                   |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |           |   |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |          |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |                                |  |
| CUMBERLAND   |  | SACRED HEART HOSPITAL  |           |   |                                  | COOK/CATERING   |          |   | RESTAURANT                        |  |  |                                |  |
| USUAL RESIDENCE 11a. NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION  |  | 13a. STATE   |           | 13b. COUNTY   |                                  | 13c. CITY OR TOWN   |          | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                   |  |  | 13e. STREET ADDRESS / ZIP CODE |  |
| MARYLAND   |  | ALLEGANY   |           | PINTO   |                                  |   |          | RT. 6, MINER ROAD / 21556   |                                   |  |  |                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |           |   |                                  |   |          |   |                                   |  |  |                                |  |
| WRESSEL  |  | WINTER   |           | MARY GRABENSTEIN  |                                  |   |          |   |                                   |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |           | 17. INFORMANT ADDRESS   |                                  |   |          |   |                                   |  |  |                                |  |
| No   |  | 215-42-4457  |           | JOHN H. NINER - ADDRESS SAME AS #13 ABOVE.  |                                  |   |          |   |                                   |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY:  |  |  |           |   |                                  |   |          |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                |  |
| IMMEDIATE CAUSE (a) myocardial infarction  |  |  |           |   |                                  |   |          |   |                                   | 1 hr   |  |                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) AS HD   |  |  |           |   |                                  |   |          |   |                                   | 5 years                                      |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) CVA   |  |  |           |   |                                  |   |          |   |                                   | 3 days                                       |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension Diabetes   |  |  |           |   |                                  |   |          |   |                                   |  |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |           |   |                                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                  |   |          |   |                                   |  |  |                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |           | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                                  |   |          |   |                                   |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 12-16 to 12-18 19 85 that (I) (we) lost saw the deceased alive on 12-16 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. |  |  |           |   |                                  |   |          |   |                                   |  |  |                                |  |
| 22b. SIGNATURE George Breza MD   |  |  |           |   |                                  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |          |   | 22c. DATE SIGNED 12-12-85         |  |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE BREZA   |  |  |           |   |                                  | 22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502  |          |   |                                   |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |           | 23c. NAME OF CEMETERY OR CREMATORY  |                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |          |   |                                   |  |  |                                |  |
| BURIAL   |  | 12-16-85   |           | ST. AMBROSE CEMETERY  |                                  | CRESAPTOWN-ALLEGANY-MARYLAND  |          |   |                                   |  |  |                                |  |
| 24. FUNERAL DIRECTOR NAME GEORGE-UPCHURCH FUNERAL HOME, P.A.   |  |  |           |   |                                  | 25a. DATE REC'D. BY REGISTRAR DEC 23 1985   |          | 25b. REGISTRAR'S SIGNATURE [Signature]  |                                   |  |  |                                |  |
| 202 GREENE STREET, CUMBERLAND, MARYLAND 21502  |  |  |           |   |                                  |   |          |   |                                   |  |  |                                |  |



350027

9:50 A  
DECEMBER 12, 1945

ELIZABETH  
HINER

ALLEANY COUNTY

S. C. B. HEART HOSPITAL



END 915 DETON DRIVE, CLEVELAND 16, OHIO

GEORGE LINDA

360025

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                       |  |   |   |                                |
|---|-----------------------|--|---|---|--------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES William NORMAN</b>   |                       |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>12</b> DAY <b>16</b> YEAR <b>85</b> 1650 AM |   |                                |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Cau</b> | 5. DATE OF BIRTH<br>MONTH <b>Jul</b> DAY <b>13</b> YEAR <b>1909</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>76</b> YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. VA</b>   |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>  |                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sacred Heart Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret Mechanic</b>  |                                |
| 13a. STREET ADDRESS<br><b>206 N. Bel Air Dr.</b>  |                       | 13b. CITY OR TOWN<br><b>Cresaptown</b>   |   | 13c. STATE<br><b>MD</b>   |                                |
| 14. FATHER'S NAME<br>FIRST <b>Alonzo</b> MIDDLE LAST <b>Norman</b>  |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Jennie</b> MIDDLE LAST <b>Roberts</b>   |   | 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland Allegany</b>                                  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |                       | 16b. SOCIAL SECURITY NO.<br><b>214-05-7284</b>   |   | 17. INFORMANT<br><b>Ruth Norman Cumberland, MD</b>  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrythemia</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) <b>Resolving myocardial infarction</b><br>(c) <b>Coronary artery heart disease</b><br>APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH <b>4 months</b><br><b>years</b>              |                       |  |   |   |                                |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Parkinsonism</b>  |                       |  |   |   |                                |
| 19a. DATE OF OPERATION  |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                                |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                       |  |   |   |                                |
| ACTUAL SIGNATURE<br><b>Paul Snow, M.D.</b>  |                       | TITLE (SPECIFY)<br><b>M.D. Dpty</b>  |   | DATE SIGNED<br><b>12/16/85</b>  |                                |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |                       | ADDRESS<br><b>Memorial Hosp. Cumberland Md</b>   |   |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                       | 23b. DATE<br><b>Dec. 19, 1985</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial p.</b>  |                                |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William G. Kight</b>   |                       | ADDRESS<br><b>Cumberland, MD</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland Allegany MD</b>   |                                |
| 23e. DATE REC'D. BY REGISTRAR<br><b>DEC 23 1985</b>   |                       | 23f. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |                                |

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

360025

William

July 13, 1902

USA

W. VA

Autosailer Res Mechanic

21502 N. Bel Air Dr. 21502

Roberts

Jennie

Norman

Alonso

214-05-7284 Ruth Norman Cumberland, MD

Mo

Burial Dec. 19, 1982, Allcrest Burial P. Cumberland Allegany MD  
William G. Knight Cumberland, MD

006177

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RUTH ISER OATES</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 23 85</b>  |  | 2b. HOUR<br><b>2137</b> M  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 11 1900</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ALLEGANY</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY COUNTY CUMBERLAND MD.</b>        |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND MD</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL HOSPITAL CUMBERLAND MD</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED SCHOOL TEACHER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |   |   | 13b. COUNTY<br><b>ALLEGANY</b>  | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>I. W. ISER</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE FAULK</b>                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-14-7028</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>RICHARD HILL 4062 OLD ORCHARD ROAD YORK PA.</b>       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Penetrating ulcer of stomach</u>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                               |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Dr. V. Ranjithan</i>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>12/24/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE COMPLETE)<br><b>DR. V. RANJITHAN</b>   |   | 22e. ADDRESS<br><b>MEMORIAL HOSPITAL CUMBERLAND MD.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>DEC 26 1985</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>QUEENS POINT CEMETERY</b>                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SILCOX-MERRITT</b>  |   | ADDRESS<br><b>DECATUR ST CUMBERLAND MD</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 30 1985</b>                                  |  |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>KEYSER MINERAL WEST VIRGINIA</b>  |   |   |   |  |  |

BP \_\_\_\_\_  
DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and mail them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00317

12 23 02 1313

DATE

SEX

RACE

HT

WT 110

HAIR

EYES

ALLERGENY COUNTY CHAMBERLAND

AGE

ALLERGENY

CHAMBERLAND NO

CHAMBERLAND NO

12-23-02-1313



100% COTTON FIBER  
TOWNS

DR. A. HAMILTON

CHAMBERLAND NO

CHAMBERLAND NO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | REG. NO.   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ARNOLD EMORY OSTER   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>DECEMBER 26, 1985                             |   |  | 2b. HOUR<br>1615<br>M  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 01 05  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80<br>YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY CUMBERLAND<br>MD                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ALLEGANY COUNTY NURSING HOME |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>machine operator            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>macaroni factory            |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>Allegany   |  | 13c. CITY OR TOWN<br>Cumberland   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>Route 4 Oldtown Road/21502     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Oster   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna L. Boor                        |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-64-9828  |  | 17. INFORMANT<br>ADDRESS<br>Mr. Clayton B. Oster Jr., Cumberland, MD  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Metastatic Carcinomatosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Carcinoma of prostate</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><i>Coronary Artery Disease, Atrial Fibrillation, Myocardial Infarction</i>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  |   |  | 22c. DATE SIGNED<br>12/27/85                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. V. A. RANJITHAN  |  |   |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>12-28-1985   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunset Memorial Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland Allegany MD                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>James F. Scarpelli, Cumberland, MD 21502  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 30 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

BP \_\_\_\_\_

C. 1500

20% COTTON FIBER

MADE IN ITALY





364128

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. RETAIN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                |  |   |   |   |  |   |                      |  |
|---|----------------|--|---|---|---|--|---|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DURCOTHY LENORA OSTER  |                |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>12 16 19 85          |   | 2b. HOUR<br>0755     |  |
| 3. SEX<br>Female  | 4. RACE<br>Cau | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 5 15   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>70 YRS.             | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>12 16 19 85                                       | 7d. HOUR<br>0755   |   |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.                 |   |                      |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Rt 4 Box 35 Oldtown Road |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Blouse Co.                                     |                      |  |
| 13a. STATE<br>Maryland  |                |  |   |   |   |  |   |                      |  |
| 13b. COUNTY<br>Allegny  |                | 13c. CITY OR TOWN<br>Cumberland  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS<br>Rt 4 Box 35 Oldtown Road 21502                |   |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Oster   |                |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna L. Boor                 |  |   |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |                |  | 16b. SOCIAL SECURITY NO.<br>214-07-1177                     |   | 17. INFORMANT<br>ADDRESS<br>Mr. Clayton Oster, Cumberland, MD-brother         |  |   |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-pulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) Acute congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Carcinoma, left breast with metastasis                                  |                |  |   |   |   |  |   |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Hypertension; Diabetes   |                |  |   |   |   |  |   |                      |  |
| 19a. DATE OF OPERATION  |                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |                      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                |  |   |   |   |  |   |                      |  |
| ACTUAL SIGNATURE<br>Paul Snow   |                |  | TITLE (SPECIFY)<br>M.D. Dpty                                |   |   | MEDICAL EXAMINER   |   | DATE SIGNED 12/16/85 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Paul Snow, M.D.   |                |  | ADDRESS<br>Memorial Hospital, Cumberland                    |   |   |  |   |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                | 23b. DATE<br>12-18-1985  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunset Memorial Park  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland Allegany Md |   |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>James F. Scarpelli, Cumberland, MD 21502  |                |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 19 1985                                  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson   |                      |  |

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(VR A15 ME (5))

RECEIVED 100 2002

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |  |   |   |   |  |
|--|--|---|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Robert Patrick  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>December 17, 1985               |   |   | 2b. HOUR<br>P.M.<br>4:35 P.  |   |   |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Cau.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 15, 1908  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |   |   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.                                 |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Luke  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>411 Pratt Street |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Administrator    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Paper Co.  |   |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Allegany  |   | 13c. CITY OR TOWN<br>Luke                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>411 Pratt Street 21540           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Marcus Anderson Patrick  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jessie Grayson        |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes          |   |   | 16b. SOCIAL SECURITY NO.<br>216-07-9359                 |  |
| 17. INFORMANT<br>ADDRESS<br>Beverly R. Jackson 115 Watson St. Thomasville Ga. 31792  |  |   |  |   |   |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Chronic Obstructive Pulmonary Disease<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 years |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 1985, to Dec 17, 1985, that (I) (we) lost saw the deceased alive on 12/16/85, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                  |  |   |  |   |   |  |   |   |   |  |
| 22b. SIGNATURE<br>Robert W. Bess, Jr. M.D.   |  |   |  |   |   | DEGREE<br>M.D.   |   | 22c. DATE SIGNED<br>12/18/85  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Robert W. Bess, Jr., M.D.   |  |   |  |   |   | 22e. ADDRESS<br>Ashfield Street, Piedmont, W.Va. 26750                               |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>Dec. 20, 1985   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Philos Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westernport, Alleg. Maryland                      |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Fredlock Funeral Home, Piedmont, W.Va. 26750   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 23 1985   |   | 25b. REGISTRAR'S SIGNATURE<br>Harwardson  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| CHAPEL OF THE HILLS<br>STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 5 3 2 8 5 7<br>REG. NO.   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR<br>1302 NATIONAL HWY<br>LAVALE, MD 21502   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>DECEMBER 24, 1985  |  |  |  | 2b. HOUR<br>M  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN THOMAS POLAND  |  |  |  | 3 SEX<br>Male   |  |  |  | 4 RACE<br>White  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 8, 1903  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS   |  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY COUNTY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SACRED HEART HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Textile   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Allegany  |  | 13c. CITY OR TOWN<br>Cresaptown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>21502<br>12810 Knobley View Dr.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Howard Poland   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Minerva Allen   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                     |  |
| 16b. SOCIAL SECURITY NO.<br>217 10 4087   |  |  |  | 17. INFORMANT<br>ADDRESS<br>Vallie V. Poland - same as above  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.A.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-24</u> , 19 <u>85</u> , to <u>12-24</u> , 19 <u>85</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Uriel Velandia M.D.</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>URIEL VELANDIA M.D.  |  |  |  |   |  | 22e. ADDRESS<br>924 SETON DRIVE CUMBERLAND, MD 21502   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>Dec. 28, 1985   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Hillcrest Burial |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland, Alleg., MD |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John J. Hafer, Jr. LaVale, MD 21502   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 27 1985   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |  |  |  |  |

803070

CHIEF OF THE BUREAU  
1000 MARSHALL WAY  
BETHESDA, MD 20814

NAME: JAMES THOMAS BOWLING BIRTHDATE: 10/10/1935

SEX: Male RACE: White DATE: May 8, 1963

RESIDENCE: Maryland USA COUNTY: MARYLAND COUNTY

EDUCATION: Completed High School

EMPLOYMENT: Maryland Department of Transportation

RELIGION: Roman Catholic

REMARKS: No other information - same as above

DATE: 5/8/63

BY: J. J. [Signature]

FOR: [Signature]

RE: [Signature]

FILE: [Signature]

NOTE: [Signature]

ADDITIONAL INFORMATION: [Signature]

REFERENCE: [Signature]

STATUS: [Signature]

REMARKS: [Signature]

DATE: 5/8/63

BY: J. J. [Signature]



008086

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |  |
|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RUTH B. RAY</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>DECEMBER 28 1985 4:30 A.M.</b>  |  |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>white</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>01-28-1908</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CUMBERLAND NURSING &amp; CONVALESCENT CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>                         |
| 13a. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>PA</b> 13c. COUNTY <b>Bedford</b> 13d. CITY OR TOWN <b>Clearville</b>  | 13e. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13f. STREET ADDRESS<br><b>Route 3 Box 325/15535</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Morris Baron</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Reine Weiner</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>085-32-0959</b>  |  | 17. INFORMANT<br>ADDRESS <b>Mrs. Elizabeth Weisman-Clearville, PA-sister</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Symptoms</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)                               |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CHF</b>  |   |   |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> 19 <b>85</b> to <b>12/28</b> 19 <b>85</b> that (I) (we) last saw the deceased alive on <b>12/26</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |
| 22b. SIGNATURE<br><b>Halevy</b>   | DEGREE <b>MD</b>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  | 22c. DATE SIGNED<br><b>12/28/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. HALEVY MD</b>  |   | 22e. ADDRESS<br><b>302 Schlegel St. Cumberland</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  | 23b. DATE<br><b>12-31-1985</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Natl' Cem.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Arlington VA</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James F. Scarpelli, Cumberland, MD 21502</b>   |   | DATE RECD. BY REGISTRAR<br><b>JAN 2 1986</b>  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 15 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



REF ID: A66111

007097

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 8 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>Emily Marie Reissig   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>12 28 85   |  | 2b HOUR<br>10:45 A.M.   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Sept. 21, 1894  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Cumberland   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lions Manor Nursing Home |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland   |  | 13b COUNTY<br>Allegany   |  | 13c CITY OR TOWN<br>Cumberland  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Edward A. Clark  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Emma Rossworm   |  | 13e STREET ADDRESS / ZIP CODE<br>614 Shriver Ave. 21502   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-05-8268  |  | 17 INFORMANT ADDRESS<br>Thomas P. Shaffer 528 Cumberland St.<br>Cumberland, MD  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Advanced ASCVD, Senility.</u>   |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>6-6</u> 19 <u>80</u> to <u>12-28</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>19</u> _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b SIGNATURE<br><u>V.A. Ranjithan</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c DATE SIGNED<br><u>12-30-85</u>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>V. A. Ranjithan, M. D.   |  | 22e ADDRESS<br>L.M.N.H. Seton Drive, Cumberland, MD 21502  |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b DATE<br>12/31/85   |  | 23c NAME OF CEMETERY OR CREMATORY<br>SS Peter & Paul  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland Allegany MD   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Leasure-Stein Funeral Home, Inc.<br>230 Baltimore Ave. Cumberland, MD 21502   |  |  |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 3 1986  |  |   |  |
|  |  |  |  | 25b REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |  |   |  |

MEDICAL CERTIFICATION

99

BP \_\_\_\_\_

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is to be notified at once.



010122

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |                                |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
|--|--|---|--|---|--|---|--|--------------------------------|--|------|--|--------|--|--------------------------|--|-----------------|--|-----------------|--|--------|--|------|--|-------|--|------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH              |  |      |  | MONTH  |  | DAY                      |  | YEAR            |  | 2b. HOUR        |  | P      |  | M    |  |       |  |      |  |
| SHIRLEY  |  | ANN   |  | RIDGELEY  |  | December 31, 1985   |  |                                |  | 1:55 |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| 3a. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | MONTH   |  | DAY                            |  | YEAR |  | 6. AGE |  | (IN YEARS LAST BIRTHDAY) |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS |  | MONTHS |  | DAYS |  | HOURS |  | MIN. |  |
| Female   |  | White   |  | May 25, 1941  |  | 44  |  | YRS.                           |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| Maryland   |  | U.S.A.  |  |   |  | Baltimore City  |  |                                |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| Cumberland   |  | Memorial Hospital   |  | Housewife   |  |   |  |                                |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| Maryland   |  | Allegany  |  | Cumberland  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 225 Oak Street                 |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                                |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| Patrick O. Myers   |  | Margaret Cunrod   |  |   |  |   |  |                                |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |                                |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |
| No   |  | 220-38-0221   |  | Merritt A. Ridgeley   |  | same as 13a-e.  |  |                                |  |      |  |        |  |                          |  |                 |  |                 |  |        |  |      |  |       |  |      |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bacterial endocarditis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 months</u> |  |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><u>13 Dec 85</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Peripheral embolus</u> |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>13 Dec 19 85</u> to <u>31 Dec 19 85</u> , that (we) last saw the deceased alive on <u>31 Dec 19 85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Dr. F.W. Miltenberger</u>                                |  | 22c. DATE SIGNED<br><u>5 Jan 86</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |  |  |   |  |
| Dr. F.W. Miltenberger   |  | 122 S. Centre St. Cumberland, Md. 21502                                       |  |  |  |   |  |

|  |  |                               |  |                                    |  |  |  |
|--|--|-------------------------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE                     |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial                                       |  | 1/3/86                        |  | Restlawn Memorial                  |  | LaVale Allegany Maryland                   |  |
| 24. FUNERAL DIRECTOR<br>NAME                 |  | 25a. DATE REC'D. BY REGISTRAR |  | 25b. REGISTRAR'S SIGNATURE         |  |  |  |
| Leasure-Stein Funeral Home, Inc.             |  | JAN 8 1986                    |  |                                    |  |  |  |
| 230 Baltimore Ave. Cumberland, MD            |  | 21502                         |  |                                    |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 13. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |   |  |   |  |   |   |  |
|--|------------------|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Roy Freeman Ritchie, Jr.  |                  |   | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>12-9 19 85 |   |  | 2b. HOUR<br>M<br>10:50 a. M   |   |  |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9/14/41   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>44 YRS.              | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.   | 7c. DATE PRONOUNCED DEAD<br>12-9 19 85  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany County, MD.                                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial Hospital - DOA |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SUPV. |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>CELANESE                                       |  |
| 13a. STATE<br>MARYLAND   |                  | 13b. COUNTY<br>ALLEGANY   |  | 13c. CITY OR TOWN<br>FROSTBURG  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ROY RITCHIE  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELEANOR YANTZ  |  | 13e. STREET ADDRESS<br>21532<br>126 WASHINGTON ST.  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-40-3145  |  | 17. INFORMANT<br>WASHINGTON ST., FROSTBURG, MD<br>MRS. ROY RITCHIE, JR., 126  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |  |   |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |                  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |   |  |   | DATE SIGNED<br>12-10-85   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |                  | ADDRESS<br>111 Penn St., Balto., Md. 21201  |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |                  | 23b. DATE<br>12/11/85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SMITHBURG CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SMITHBURG WASHINGTON MD                           |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOWERS FUNERAL HOME  |                  | ADDRESS<br>60 W. MAIN ST.<br>FROSTBURG  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 16 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>   |   |  |

4-1551-1

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352060

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |                           |  |
|---|--|--|--|---|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FLORENCE I ROBINETTE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>DECEMBER 9, 1985</b>           |   | 2b. HOUR<br><b>1:35P.</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 4, 1905</b>                 |                           |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |                           |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.  |  | 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>                            |                           |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL HOSPITAL</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Liquor Store</b>                  |                           |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Allrgany</b>   |  | 13c. CITY OR TOWN<br><b>Corriganville</b>                                 |                           |  |
| 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>Fords Crossing 21524</b>  |  |   |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Robinette</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Mae Kline</b> |   |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-05-6039</b>   |  | 17. INFORMANT ADDRESS<br><b>Duane Robinette, Artemas, PA.</b>             |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>COPD, UTI</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  |  |   |                           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                           |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |                           |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |                           |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |                           |  |
| 22a. SIGNATURE<br><b>DR. ZAMAN</b>  |  | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. ZAMAN</b>  |  | 22c. DATE SIGNED<br><b>12/9/85</b>  |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. ZAMAN</b>   |  | 22e. HOSPITAL NAME<br><b>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502</b>   |  |   |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Dec. 12, 1985</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial</b>             |                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland Allegany MD</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William G. Kight Cumberland, MD</b>   |  |   |                           |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 16 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |                           |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

3520-0

|         |           |               |               |
|---------|-----------|---------------|---------------|
| Female  | White     | Oct. 4, 1902  | 80            |
| MD      | USA       | X             | Allegany      |
| MD      | Allegany  | Corriganville | X             |
| Charles | Robinette | Bessie        | Mae           |
| No      | Robinette | Robinette     | Allegany, Pa. |



William G. Knight Cumberland, MD  
Dec. 12, 1985 Millicent Burial Cumberland Allegany MD

365214

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN CHARLES RODENHAUSER</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 19, 1985</b>   |  | 2b HOUR<br><b>3:50</b><br>p.m.  |  |
| 3 SEX<br><b>male</b>  |  | 4 RACE<br><b>white</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01-25-1905</b>  |  |
| 6a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |  |
| 10 CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.  |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ret. Shift Supt.</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Fire Co.</b>  |  |   |  |
| 13a STATE<br><b>MD</b>  |  | 13b COUNTY<br><b>Allegany</b>  |  | 13c CITY OR TOWN<br><b>LaVale</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert J. Rodenhauser</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura V. Goss</b>   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br><b>214-05-9649</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Josephine Rodenhauser, LaVale, MD-wife</b>                             |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 hours</b><br><b>2 years</b> |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)                              |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a I certify that (1) (this hospital) attended the deceased from <b>12-11</b> , 19 <b>85</b> , to <b>12-19</b> , 19 <b>85</b> , that (2) (we) lost<br>saw the deceased alive on <b>12-19</b> , 19 <b>85</b> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated<br>above (4) (we) (did not) view the body after death   |  |  |  |   |  |
| 22b SIGNATURE<br><b>William Lamm MD</b><br>DEGREE   |  |  |  | 22c DATE SIGNED<br><b>12-19-85</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. William Lamm</b>   |  |  |  | 22e ADDRESS<br><b>Memorial Hospital Medical Building<br/>Cumberland, MD 21502</b>                         |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>12-22-1985</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>James F. Scarpelli, Cumberland, MD 21502</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland Allegany MD</b>   |  | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE<br><b>DEC 23 1985</b>                              |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it from page 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

SECRET

RECEIVED OCTOBER 20 1964

UNITED STATES DEPARTMENT OF DEFENSE



353120

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Eldridge P. Saville   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>December 6, 1985   |  | 2b. HOUR<br>6:50P M  |
| 3 SEX<br>Male   | 4 RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 27 93  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Augusta, W. Va.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.                            |  |
| 10 CITY OR TOWN OF DEATH<br>Cumberland  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lions Manor Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>textile                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>402 Grand Ave., Cumberland, Md. 21502        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William T. Saville  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Harriet E. Wolford   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |   | 16b. SOCIAL SECURITY NO.<br>WW I 217-10-4146  |   | 17 INFORMANT ADDRESS<br>Lions Manor Nursing Home, Cumberland, Md. 21502        |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Senility</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)<br><u>Deep vein thrombosis. Status Post carcinoma of colon</u>   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> 19 <u>88</u> to <u>12/6</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/4</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><u>V. A. Ranjithan</u>  |   |   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Viola Ranjithan, M.D.</u>   |   |   |   | 22e. ADDRESS<br>Lions Manor Nursing Home, Cumberland, Md. 21502                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>12-09-1985   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunset Memorial Park                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland Allegany MD  |   | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE<br><u>UTC 1.1.1985</u>   |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>James F. Scarpelli, Cumberland, MD 21502   |   |   |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

051648

20% COTTON FIBER



20% COTTON FIBER

006174

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |  |  |  |                     |  |
|--|--|--|--|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE N. LAST ROLLER SELF   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>DECEMBER 26, 1985 |  | 2b. HOUR<br>9:15A M |  |
| 3. SEX<br>female   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05-08-1890                                     |                     |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS.   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |                     |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.   |  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MEMORIAL HOSPITAL                           |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |                     |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>own home  |  | 13a. STREET ADDRESS / ZIP CODE<br>125 Polk Street/21502  |  |  |                     |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Allegany  |  | 13c. CITY OR TOWN<br>Cumberland  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>David Roller   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Hartman   |  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-20-6508   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Charlotte Torbet, Cumberland, MD-daughter           |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiomyopathy Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA + CAD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |  |  |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |  |                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  |                     |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 25</u> 19 <u>85</u> to <u>Dec. 26</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 25</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, so state.)   |  |  |  |  |                     |  |
| 22b. SIGNATURE<br><u>Dr. Anthony Bollino</u>   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>12-26-85   |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. ANTHONY BOLLINO   |  | 22e. ADDRESS<br>955 Frederick St.<br>Cumberland, Maryland 21502  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12-28-1985  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Friends Cove Cem.                              |                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bedford PA   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>James F. Scarpelli, Cumberland, MD 21502   |  |  |                     |  |
| 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John E. ...</u>   |  |  |                     |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove this certificate from the file and return it to the funeral director. It should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic, the medical examiner must be notified of course.



451600



347047

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                     |  |                              |  |   |  |  |  |                                |  |   |  |                                      |  |   |  |  |  |                              |  |                                   |  |  |  |
|-------------------------------------|--|------------------------------|--|---|--|--|--|--------------------------------|--|---|--|--------------------------------------|--|---|--|--|--|------------------------------|--|-----------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST                        |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH              |  | MONTH   |  | DAY                                  |  | YEAR  |  | 2b. HOUR   |  | 4:30                         |  |                                   |  |  |  |
| RUSSELL                             |  | HENRY                        |  | SHAFFER   |  |  |  | December 5, 1985               |  |   |  |                                      |  |   |  | P.   |  | M                            |  |                                   |  |  |  |
| 3. SEX                              |  | 4. RACE                      |  | 5. DATE OF BIRTH  |  | 6. AGE   |  | 7. UNDER 1 YEAR                |  | 8. UNDER 24 HRS   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION        |  | 12. USUAL OCCUPATION         |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Male                                |  | White                        |  | Dec. 8, 1896  |  | 88   |  | MONTHS                         |  | DAYS  |  | Allegany                             |  | Cumberland  |  | Memorial Hospital  |  | Ret. Owner                   |  | Auto Parts                        |  |  |  |
| 7a. BIRTHPLACE                      |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  | 10. CITY OR TOWN OF DEATH      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12. USUAL OCCUPATION                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  | 13a. STREET ADDRESS / ZIP CODE                                 |  | 13b. CITY OR TOWN            |  | 13c. COUNTY                       |  |  |  |
| Va.                                 |  | USA                          |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | Allegany   |  | Cumberland                     |  | Memorial Hospital                                       |  | Ret. Owner                           |  | Auto Parts  |  | 507 Conrad Ave. 21502  |  | Cumberland                   |  | Allegany                          |  |  |  |
| 13a. STATE                          |  | 13b. COUNTY                  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS / ZIP CODE |  | 13f. CITY OR TOWN                                       |  | 13g. COUNTY                          |  | 13h. ZIP CODE   |  | 13i. CITY OR TOWN  |  | 13j. COUNTY                  |  | 13k. ZIP CODE                     |  |  |  |
| MD                                  |  | Allegany                     |  | Cumberland  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 507 Conrad Ave. 21502          |  | Cumberland  |  | Allegany                             |  | 21502   |  | Cumberland   |  | Allegany                     |  | 21502                             |  |  |  |
| 14. FATHER'S NAME                   |  | 15. MOTHER'S MAIDEN NAME     |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT                  |  | 18. CAUSE OF DEATH                                      |  | 19. DATE OF OPERATION                |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  | 21a. ACCIDENT WAS UNDERLYING |  | 21b. TIME OF INJURY               |  | 21c. HOW INJURY OCCURRED                           |  |
| Clinton                             |  | Nancy                        |  | NO  |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  | HOUR A.M. MONTH DAY YEAR          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |
| MIDDLE                              |  | LAST                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 213-12-9773  |  | Anna Shafer, Cumberland, MD    |  | Bullet to the head                                      |  | 11/25/85                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | OR CONTRIBUTING              |  |                                   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

## MEDICAL CERTIFICATION

BP

Male

White

Dec. 8, 1996

88

VA.

USA

XX

MD

Allegany

Cumberland

X

507 Conard Ave.

21502

Clinton

Shaffer

Nancy

Trye

NO

Anna Shaffer, Cumberland, MD

Burial

Dec. 8, 1995

Allegany MD

William G. Right

Cumberland, MD

006220

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |   |                           |  |  |
|--|--|---|---|---|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MICHAEL B. SHEPARD</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>DECEMBER 22, 1985</b> |   | 2b. HOUR<br><b>0517</b> M |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Cau</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 25 1970</b>   |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>15</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>  |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>   |  |
| 13a. STATE<br><b>WV</b>  |  | 13b. COUNTY<br><b>Mineral</b>   |   | 13c. CITY OR TOWN<br><b>Keyser</b>  |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William A. Shepard</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susan R. Barse</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                           |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>800-04-6870</b>   |  | 17. INFORMANT<br>ADDRESS <b>216 W. Douglass St. Reading, PA 19601</b>   |   |   |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Muscular Dystrophy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>   |  |   |   |   |                           |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>N/A</b>   |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> <b>N/A</b><br>ON THE WAY TO OR FROM WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)<br><b>N/A</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>   |                           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/23/85</b> , 19____, to <b>12/23/85</b> , 19____, that (I) (we) last saw the deceased alive on <b>12/23/85</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                  |  |   |   |   |                           |  |  |
| 22b. SIGNATURE<br><b>Shan Nathan</b>   |  |   |   | DEGREE<br><b>MEDICAL BUILDING</b>   |                           | 22c. DATE SIGNED<br><b>12/24/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. SHAN NATHAN</b>  |  |   |   | 22e. ADDRESS<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD 21502</b>  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>12/28/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Omps Cremation Service</b>   |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Winchester VA</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>A. Craig Rotruck 85 S Main St Keyser, WV</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 31 1985</b>   |                           |  |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John K. ...</b>  |                           |  |  |

MEDICAL CERTIFICATION

DHMH - 10-60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, page 3, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the incident is a reportable event, and must be reported to the State Dept. of Health and Mental Hygiene.



353060

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |         |  |   |  |  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
|--|--|---------|--|---|--|--|--|---|---|------------------|--|---|--|--|--|---|--|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         | FIRST MIDDLE LAST  |   |  | 2a. DATE KNOWN OF DEATH  |  |   | MONTH DAY YEAR  |                  |  | 2b. HOUR  |  |  |  |   |  |                       |  |
| Diana Mae Shirley  |  |         |  |   |  | 12/11/1985   |  |   |   |                  |  | M   |  |  |  |   |  |                       |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.  |   | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD  |  | 2d. HOUR                                     |  |   |  |                       |  |
| Female   |  | White   |  | Oct. 9, 1945  |  | 40 YRS.  |  | MONTHS DAYS HOURS MIN   |   |                  |  | 12/11/1985  |  | 8:22 A M                                     |  |   |  |                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                  |  |   |  |  |  |   |  |                       |  |
| Penna.   |  |         | U.S.A.   |   |  |  |  |   | Allegany County, MD.  |                  |  |   |  |  |  |   |  |                       |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |   |  |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |   |  |                       |  |
| Frostburg  |  |         | Frostburg Hospital                                       |   |  |  |  |   | Clerk   |                  |  | County Gvt.   |  |  |  |   |  |                       |  |
| 13a. STATE   |  |         |  |   |  |  |  |   |   |                  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                            |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |
| Maryland   |  |         |  |   |  |  |  |   |   |                  |  | Allegany  |  | Frostburg                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 240 Center St., 21532 |  |
| 14. FATHER'S NAME  |  |         |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| FIRST MIDDLE LAST  |  |         |  |   |  | FIRST MIDDLE LAST  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| Frederick W. Walker  |  |         |  |   |  | Freda House  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  |   |  | 16b. SOCIAL SECURITY NO.   |  |   |   |                  |  | 17. INFORMANT ADDRESS   |  |  |  |   |  |                       |  |
| No   |  |         |  |   |  | 202-38-8488  |  |   |   |                  |  | Christina Shirley, Same as 13e                                      |  |  |  |   |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |  |  |   |   |                  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |                       |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |   |  |  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| IMMEDIATE CAUSE (a) Multiple Injuries  |  |         |  |   |  |  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |         |  |   |  |  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a.   |  |         |  |   |  |  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |   |   |                  |  | 20. AUTOPSY?  |  |  |  |   |  |                       |  |
|  |  |         |  |   |  |  |  |   |   |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |                       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  | 21b. TIME OF INJURY   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |                  |  |   |  |  |  |   |  |                       |  |
|  |  |         |  | ? P.M. 12/11/1985   |  |  |  | driver in auto/auto collision   |   |                  |  |   |  |  |  |   |  |                       |  |
| 21d. INJURY OCCURRED   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  |  | 21f. LOCATION   |   |                  |  |   |  |  |  |   |  |                       |  |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |         |  | roadway   |  |  |  | Rt. 36, southbound, Allegany Co., Md.   |   |                  |  |   |  |  |  |   |  |                       |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |   |  |  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| TITLE (SPECIFY)  |  |         |  |   |  |  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |
| ACTUAL SIGNATURE   |  |         |  |   |  |  |  |   |   |                  |  |   |  | M.D. Assistant MEDICAL EXAMINER              |  | DATE SIGNED 12/11/85  |  |                       |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  |   |  |  |  |   |   |                  |  |   |  | Gregory R. Kauffman, M.D.                    |  | ADDRESS 111 Penn St.  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   |                  |  | 23d. LOCATION   |  |  |  |   |  |                       |  |
| Burial   |  |         |  | Dec. 13 '85   |  |  |  | Salisbury Cemetery  |   |                  |  | Salisbury, Penna.   |  |  |  |   |  |                       |  |
| 24. FUNERAL DIRECTOR   |  |         |  |   |  |  |  |   |   |                  |  |   |  | DATE REC'D. BY REGISTRAR                     |  | 25b. REGISTRAR'S SIGNATURE  |  |                       |  |
| NAME ADDRESS   |  |         |  |   |  |  |  |   |   |                  |  |   |  | DEC 16 1985                                  |  | John Davidson   |  |                       |  |
| Durst Funeral Home, Frostburg, Md.   |  |         |  |   |  |  |  |   |   |                  |  |   |  |  |  |   |  |                       |  |

328030

Remains with 601, 1941

.....

Black

and 601, 1941

Black

Black 601, 1941

601-1941 and 601, 1941

1

328030

Black 601, 1941 and 601, 1941  
Black 601, 1941 and 601, 1941



009061

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |  |  |  |  |                       |  |
|---|--|--|--|---|--|--|--|--|--|--|--|-----------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>IVA  |  | MIDDLE<br>MUREL  |  | LAST<br>SHOEMAKER  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>December 31, 1985 |  | 2b. HOUR<br>7:35 P.M. |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 9 1934   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 72 HRS.<br>HOURS MIN.                        |  |                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.   |  |  |  |  |  |                       |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Poultry Mkt.<br>Rockingham  |  |  |  |  |  |                       |  |
| 13a. STATE<br>WV  |  | 13b. COUNTY<br>Hampshire   |  | 13c. CITY OR TOWN<br>Romney   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE<br>176 South High Street 99999            |  |  |  |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence Barr   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Wilfong   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>236-50-0661   |  | 17. INFORMANT<br>ADDRESS<br>Cheryl Rotruck, 330 Wirgman Ave., Romney, WV |  |  |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Ischemic cardiomyopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |  |  |  |  |  |  |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |  |  |  |  |  |                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> 19 <u>85</u> to <u>12/31</u> 19 <u>85</u> , that (I) (we) lost<br>saw the deceased alive on <u>12/31</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                     |  |  |  |   |  |  |  |  |  |  |  |                       |  |
| 22b. SIGNATURE<br><u>P. Halmos</u>  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1/1/86   |  |  |  |  |  |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Peter Halmos   |  | 22e. ADDRESS<br>Memorial Hospital & Medical Center<br>Cumberland, MD 21502   |  |   |  |  |  |  |  |  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/3/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Old Pine Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Purgitsville Hampshire WV  |  |  |  |  |  |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Keith S. Shaffer  |  | ADDRESS<br>Shaffer Funeral Home, Romney, WV 26757  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John E. ...</u>   |  |  |  |  |  |                       |  |

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

000001



WINTERBORN

— PAPER NOTION —

JAN 8 1898

364167

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |                                      |  |                                   |  |
|---|--|--|---|---|--------------------------------------|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |   |                                      | 2b. HOUR   |                                   |  |
| JAMES ELWOOD SMITH  |  |  | December 18, 1985   |   |                                      | 9:20 A <sub>M</sub>  |                                   |  |
| 3 SEX   | 4 RACE   | 5 DATE OF BIRTH  | 6 AGE (IN YEARS (LAST BIRTHDAY))                                    |   |                                      | 7. IF UNDER 1 YEAR   |                                   |  |
| Male  | White  | Aug. 14, 1909  | 76 YRS.   |   |                                      | MONTHS DAYS HOURS MIN.   |                                   |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 8b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                   |  |
| WV  | U.S.A.   |  |   |   | Allegany MD.                         |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Cumberland  | Memorial Hospital  |  |   | Contractor  |                                      |  | Construction                      |  |
| 13a. STATE  |  |  | 13b. COUNTY   |   |                                      | 13c. CITY OR TOWN  |                                   |  |
| WV  |  |  | Hampshire   |   |                                      | Springfield  |                                   |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |   |                                      |  |                                   |  |
| Ace Albert Smith  |  |  | Ada Malcolm   |   |                                      |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |   |                                      | 17. INFORMANT ADDRESS  |                                   |  |
| NO  |  |  | 214-05-9085   |   |                                      | Edith Smith, Star Rt. 1, Box 2 A Springfield, WV   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |   |   |                                      |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) <u>End stage ischemic cardiomyopathy</u>  |  |  |   |   |                                      |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes</u>  |  |  |   |   |                                      |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |   |   |                                      |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |   |   |                                      |  |                                   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |                                      | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |   |   |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |   |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |                                   |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |   |                                      |  |                                   |  |
|   |  |  | P.M. 19   |   |                                      |  |                                   |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                      | 21f. LOCATION  |                                   |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   |   |                                      | STREET CITY OR TOWN COUNTY STATE   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |                                      |  |                                   |  |
| 22b. SIGNATURE  |  |  |   |   |                                      | DEGREE   |                                   | 22c. DATE SIGNED   |
| <u>H.C. Merrick</u>   |  |  |   |   |                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 12/18/85   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |   |                                      | 22e. ADDRESS   |                                   |  |
| Dr. H.C. Merrick  |  |  |   |   |                                      | Medical Building<br>Memorial Hospital Cumberland, Md. 21502  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION                     |  |
| Burial  |  |  | 12/21/85  |   | Wesley Chapel Cemetery               |  | CITY OR TOWN COUNTY STATE         |  |
|   |  |  |   |   | Points Hampshire WV                  |  |                                   |  |
| 24. FUNERAL DIRECTOR  |  |  |   |   |                                      |  |                                   |  |
| NAME Keith S. Shaffer ADDRESS Shaffer Funeral Home, Romney, WV  |  |  |   |   |                                      |  |                                   |  |
| 25a. DATE REC'D. BY REGISTRAR   |  |  |   |   |                                      | 25b. REGISTRAR'S SIGNATURE   |                                   |  |
| DEC 23 1985   |  |  |   |   |                                      | <u>John Davidson</u>   |                                   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of burial.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonated pages 1 and 2 and should be kept with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
BP 999999

WILSON

20% COTTON - 25M

100% COTTON



DEC 23 1950

353169

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. (PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000)

BP

DHMH-17  
(VR A15 ME (3))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |           |  |
|---|--|---------|-------------------|---|--|-------------------------|--|--|----------------|------------------|--|---|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         | FIRST MIDDLE LAST |   |  | 2b. DATE KNOWN OF DEATH |  |  | MONTH DAY YEAR |                  |  | 2d. HOUR  |  |           |  |
| Cecilia M. Spates   |  |         |                   |   |  | 12 5 1985               |  |  |                |                  |  | 2 A M   |  |           |  |
| 1. SEX  |  | 4. RACE |                   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)       |  | IF UNDER 1 YR.   |                | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR  |  |
| Female  |  | White   |                   | Aug. 23, 1902   |  | 83 YRS.                 |  | MONTHS   |                | DAYS             |  | 12 5 1985   |  | 11:20 A M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?                                |  |                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |           |  |
| Maryland  |  |         |                   | U.S.A.  |  |                         |  |  |                |                  |  | Allegany MD.  |  |           |  |
| 10. CITY OR TOWN OF DEATH   |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |           |  |
| Frostburg   |  |         |                   | 76 Broadway   |  |                         |  | Supervisor   |                |                  |  | U.S. Govt.  |  |           |  |
| 13a. STATE  |  |         |                   | 13b. COUNTY   |  |                         |  | 13c. CITY OR TOWN  |                |                  |  | 13d. INSIDE CITY LIMITS?  |  |           |  |
| Maryland  |  |         |                   | Allegany  |  |                         |  | Frostburg  |                |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |           |  |
| 14. FATHER'S NAME   |  |         |                   | 15. MOTHER'S MAIDEN NAME                                    |  |                         |  | 13e. STREET ADDRESS  |                |                  |  |   |  |           |  |
| Frank P. Spates   |  |         |                   | Margaret Carney   |  |                         |  | 76 Broadway, 21532   |                |                  |  |   |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |         |                   | 16b. SOCIAL SECURITY NO.                                    |  |                         |  | 17. INFORMANT  |                |                  |  | ADDRESS   |  |           |  |
| No  |  |         |                   | 224-60-6479   |  |                         |  | Frank Spates, Westminster, Cal.  |                |                  |  |   |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |                   |   |  |                         |  |  |                |                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |           |  |
| PART I DEATH WAS CAUSED BY:   |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |           |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u>  |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |           |  |
| (b) <u>Disease</u>  |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |           |  |
| (c)   |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |           |  |
| 19a. DATE OF OPERATION  |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                         |  |  |                |                  |  | 20. AUTOPSY?  |  |           |  |
|   |  |         |                   |   |  |                         |  |  |                |                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |                   | 21b. TIME OF INJURY   |  |                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                |                  |  |   |  |           |  |
|   |  |         |                   | HOUR A.M. MONTH DAY YEAR                                    |  |                         |  |  |                |                  |  |   |  |           |  |
|   |  |         |                   | P.M. 19   |  |                         |  |  |                |                  |  |   |  |           |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                         |  | 21f. LOCATION  |                |                  |  |   |  |           |  |
|   |  |         |                   |   |  |                         |  | STREET   |                |                  |  | CITY OR TOWN COUNTY STATE   |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |                   |   |  |                         |  |  |                |                  |  |   |  |           |  |
| ACTUAL SIGNATURE  |  |         |                   | TITLE (SPECIFY)   |  |                         |  | DATE SIGNED  |                |                  |  |   |  |           |  |
| Francisco Reyes   |  |         |                   | Deputy  |  |                         |  | 12-5-85  |                |                  |  |   |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |                   | ADDRESS   |  |                         |  |  |                |                  |  |   |  |           |  |
| Francisco Reyes, M.D.   |  |         |                   | 900 Seton Dr., Cumberland, Md.                              |  |                         |  |  |                |                  |  |   |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |                   | 23b. DATE   |  |                         |  | 23c. NAME OF CEMETERY OR CREMATORY   |                |                  |  | 23d. LOCATION   |  |           |  |
| Burial  |  |         |                   | Dec. 9 '85  |  |                         |  | St. Michaels Cem.  |                |                  |  | Frostburg, Allegany, Md.  |  |           |  |
| 24. FUNERAL DIRECTOR  |  |         |                   | 25a. DATE REC'D. BY REGISTRAR                               |  |                         |  | 25b. REGISTRAR'S SIGNATURE   |                |                  |  |   |  |           |  |
| NAME  |  |         |                   | ADDRESS   |  |                         |  |  |                |                  |  |   |  |           |  |
| Durst Funeral Home, Frostburg, Md   |  |         |                   | DEC 13 1985   |  |                         |  | Julia Davidson   |                |                  |  |   |  |           |  |



07/84  
25M

DHMH - 17  
(VR A15 ME (5))

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. TO COMPLETE THIS CERTIFICATE, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1 THROUGH 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-1. GIVE PAGE 5 TO YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL. IF NECESSARY, PLEASE TELEPHONE 201 W. PACE ST., BALTIMORE, MD. 21201.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Willie C Sponaugle</b>  |  | 6. DATE KNOWN<br>DEATH ESTI-<br>MATED <b>XX</b>  |  | 7b. HOUR<br><b>12 21</b>   |  | 7b. YEAR<br><b>1985</b>   |  | 7b. HOUR<br><b>1055A</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cau</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 26 05</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>80</b> YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>W. Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED<br>WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/>                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.                                     |  | 12b. HOUR<br><b>12 21</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><b>Bottling Ret.</b>   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br><b>Brewing Co</b>                                       |  | 24. HOUR<br><b>1055A</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Allegany</b>   |  | 13c. CITY OR TOWN<br><b>Cumberland</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>701 Elm Street 21502</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ashby Sponaugle</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary C. Munlix</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-05-4778</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Corda Sponaugle Same as above</b>                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>8880 Cardio-pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost. } (b) <b>Hepato-renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic alcoholic liver disease</b>                 |  |  |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>sudden</b><br><b>2-3 weeks</b><br><b>years</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic sub-dural hematoma; coronary artery heart disease; chronic heart failure</b>   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING CAUSE OF DEATH<br>21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>400 P.M. 11 8 85</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Pt fell at home. Sub-dural. Pt fell again in</b><br><b>hospital 12/10/85 0330hrs</b> |  |   |  |  |  |
| 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br><b>11/8/85 701 Elm Street.</b>  |  | 21f. STREET<br><b>12/10/85 3 South Memorial Hospital</b>   |  | CITY OR TOWN<br><b>Cumberland</b>  |  | COUNTY<br><b>Allegany</b>   |  | STATE<br><b>MD</b>   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |  |  |
| ACTUAL<br>SIGNATURE<br><b>Paul Snow, M.D.</b>   |  | TITLE (SPECIFY)<br><b>Dpty</b>   |  | MEDICAL EXAMINER   |  | DATE<br>SIGNED<br><b>12/21/85</b>   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Memorial Hospital</b>  |  | ADDRESS<br><b>Cumberland Maryland 21502</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Dec. 24, 1985</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PLeasant Grove C</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Cumberland Allegany MD</b>                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William G. Knight</b>  |  | ADDRESS<br><b>Cumberland, MD</b>   |  | 15b. DATE REC'D. BY REGISTRAR<br><b>DEC 26 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |



304333



W. Va.

USA

Shady

Sponangle

Mary

C.

Munlix

Corba Sponangle same as above

21502

Bottler Ref.

Browning Co

William G. Right Cumberland, MD  
Burial Dec. 24, 1985 Pleasant Grove C. Cumberland Allegany, MD

353130

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (SEE PAGE 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS PAGE. IF THE CHIEF MEDICAL EXAMINER IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WHICH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
|---|--|---------|--|------------------|--|--|--|----------------|---|------------------|--|---|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         | FIRST MIDDLE LAST  |                  |  | 2a. DATE KNOWN OF DEATH  |  |                | MONTH DAY YEAR  |                  |  | 2b. HOUR  |  |           |  |
| Charles W. Stansberry   |  |         |  |                  |  | 12-2 19 85   |  |                |   |                  |  | M   |  |           |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR. |   | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD  |  | 2d. HOUR  |  |
| Male  |  | White   |  | Aug. 28, 1928    |  | 57 YRS.  |  |                |   |                  |  | 12-2 19 85  |  | 2:04 p.m. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                  |  |   |  |           |  |
| West Virginia   |  |         | U.S.A.   |                  |  |  |  |                | Allegany County, MD   |                  |  |   |  |           |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |  |  |  |                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |           |  |
| Cumberland  |  |         | Memorial Hospital  |                  |  |  |  |                | Professor   |                  |  | College   |  |           |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| 13a. STATE  |  |         | 13b. COUNTY  |                  |  | 13c. CITY OR TOWN  |  |                | 13d. INSIDE CITY LIMITS?  |                  |  | 13e. STREET ADDRESS   |  |           |  |
| Maryland  |  |         | Allegany   |                  |  | Frostburg  |  |                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  |  | 13 Park Ave., 21532   |  |           |  |
| 14. FATHER'S NAME   |  |         |  |                  |  | 15. MOTHER'S MAIDEN NAME   |  |                |   |                  |  |   |  |           |  |
| David F. Stansberry   |  |         |  |                  |  | Trevia Kinney  |  |                |   |                  |  |   |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |         |  |                  |  | 16b. SOCIAL SECURITY NO.   |  |                |   |                  |  | 17. INFORMANT   |  |           |  |
| Yes   |  |         |  |                  |  | 1949-52  |  |                |   |                  |  | 232-40-8844   |  |           |  |
|   |  |         |  |                  |  | Records: Raiguel Funeral Home  |  |                |   |                  |  |   |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| PART I DEATH WAS CAUSED BY:   |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| IMMEDIATE CAUSE (a) Multiple Injuries   |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| (b)   |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| (c)   |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| 19a. DATE OF OPERATION  |  |         |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                |   |                  |  | 20. AUTOPSY?  |  |           |  |
|   |  |         |  |                  |  |  |  |                |   |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |                  |  | 21b. TIME OF INJURY  |  |                |   |                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |           |  |
|   |  |         |  |                  |  | 2:00 P.M. 12-2 19 85   |  |                |   |                  |  | subject pinned between autos  |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |         |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                |   |                  |  | 21f. LOCATION   |  |           |  |
|   |  |         |  |                  |  | road-east lane   |  |                |   |                  |  | St. 48, Cumberland, Allegany Co., Maryland                                    |  |           |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |                  |  |  |  |                |   |                  |  |   |  |           |  |
| ACTUAL SIGNATURE  |  |         |  |                  |  | TITLE (SPECIFY)  |  |                |   |                  |  | DATE SIGNED   |  |           |  |
| Thomas D. Smith   |  |         |  |                  |  | Acting Chief   |  |                |   |                  |  | 12-2-85   |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |  |                  |  | ADDRESS  |  |                |   |                  |  |   |  |           |  |
| Thomas D. Smith, M.D.   |  |         |  |                  |  | 111 Penn St., Balto., Md. 21201  |  |                |   |                  |  |   |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         | 23b. DATE  |                  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                | 23d. LOCATION   |                  |  |   |  |           |  |
| Burial  |  |         | Dec. 6, 1985   |                  |  | Lawford Cemetery   |  |                | Newberne Ritchie W. Va.   |                  |  |   |  |           |  |
| 24. FUNERAL DIRECTOR  |  |         |  |                  |  | 25a. DATE REC'D. BY REGISTRAR  |  |                |   |                  |  | 25b. REGISTRAR'S SIGNATURE  |  |           |  |
| Durst Funeral Home, Frostburg, Md. 21532  |  |         |  |                  |  | DEC 10 1985  |  |                |   |                  |  | John Durst  |  |           |  |

MEDICAL CERTIFICATION

350130

Wife and Virginia

W. S. A.

College

Johnson

John

13 Park Ave., 51533

X

On

Alimony

David

Finney

Trovis

Stamper

P.

David



Partial - Dec. 1, 1985 - Bedford Cemetery

David General Horn, Trovis, W. S. 51533 DEC 1 1985

365225

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove 450-500-5000. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 8 / 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                            |  |  |  |   |  |  |  |
|---|--|---|---|---|----------------------------|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Martin BURKE Sharp</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>12 17 85</b>                                |   | 2b. HOUR<br><b>11:25 A</b> |  |  |  |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 9 1912</b>   |                            | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>73</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>73</b>   |   | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>73</b> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sacred Heart Hospital</b> |   |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED KELLY SPRINGFIELD TIRE CO</b>                               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>ALLEGANY</b>  |   | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>835 GEPHART DRIVE 21502</b>   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>H. HALL SHARP</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY M. MARTIN</b>  |                            |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW1</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>MARIAN SHARP 835 GEPHART DRIVE CUMBERLAND MD.</b>  |                            |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery</b><br><b>thrombosis acute MI</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Severe Mitral Regurg CVA</b> |  |   |   |   |                            |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |   |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                     |   |                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b. PART I OR PART 2)  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Home</b> |   |                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>17th St. Dec. 17 85</b>  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) (the deceased from) <b>Dec. 26 1985</b> to <b>Dec. 17 1985</b> , that (I) (we) lost<br>saw the deceased alive on <b>Dec. 26 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.   |  |   |   |   |                            |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Terry Williams</b>   |  |   | DEGREE<br><b>MD</b>   |   |                            | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>Dec. 18, 1985</b>                                      |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR TERRY WILLIAMS</b>   |  |   | 22e. ADDRESS<br><b>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND</b>                  |   |                            |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>DEC 20 1985</b>   |   |                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>rest lawn cemetery</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAVALE ALLEGANY MARYLAND</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 23 1985</b>                                   |   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>John T. ...</b>   |  |  |   |  |  |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Paul W Steinberger   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>December 31, 1985  |  | 2b. HOUR<br>M  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 1, 1897  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Germany  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany County MD.                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>803 Tanpley Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman                    | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |   |   | 13b. CITY OR TOWN<br>Allegany   |  |  |
| 13c. CITY OR TOWN<br>Cumberland   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>803 Tanpley Ave. 21502  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gustau Steinberger  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unknown  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>---   | 17. INFORMANT<br>ADDRESS<br>Milly G. Steinberger same as 13a-e                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of the Liver</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Primary Carcinoma of the kidneys</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 mo.<br>6 years   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Cysts both kidneys -CVA - Coronary Arteriosclerosis-Auricular</u>   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/18/51</u> , 19 <u>51</u> , to <u>12/31/</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>12/31</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Samuel M. Jacobson</i>   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>1-2-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL M. JACOBSON, MD.  |   | 22e. ADDRESS<br>50 PERSHING ST., CUMBERLAND, MD.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>1/2/86   | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland Allegany MD   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leasure-Stein Funeral Home, Inc.<br>230 Baltimore Ave. Cumberland, MD 21502   |   |   |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1986   |   |   |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Samuel M. Jacobson</i>   |   |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified before.

*[Illegible text]*



006169

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the illness and date be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Marguerite E. Stinger</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>December 24, 1985</b> |  |  | 2b. HOUR<br><b>7:08pm</b>   |  |  |  |
| 3. SEX<br><b>female</b>   |  | 4 RACE<br><b>white</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>03-26-1904</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 72 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.                                      |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hosp. &amp; Med. Bldg.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>supervisor</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>telephone co.</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |   |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Allegany</b>  |  | 13c. CITY OR TOWN<br><b>Cumberland</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>135 N. Mechanic Street/21502</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Clarence F. Fraley</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Anna Marie Sweitzer</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-05-8994</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Walter D. Stinger, Orlando, FL - son</b>   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(AMI)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 24</b> , 19 <b>85</b> , to <b>Dec. 24</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>Dec. 24</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.     |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. William D. Lamm</b>  |  |   |  | DEGREE <b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>12-26-85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. William D. Lamm</b>   |  |   |  | 22e. ADDRESS<br><b>Memorial Hospital Medical Bldg.<br/>Cumberland, MD 21502</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12-27-1985</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Cumberland Allegany MD</b>                        |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br><b>James F. Scarpelli, Cumberland, MD 21502</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 30 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>  |  |  |  |

631680

20% COTTON FIBRE

MADE IN INDIA



MADE IN INDIA

006173

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |                              |  |
|--|--|--|---|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MILDRED LOUISE TALLMAN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 27, 1985</b> |  | 2b. HOUR<br><b>9:45 A.M.</b> |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06-15-1912</b>  |                              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>OH</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN.   |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b>                          |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD   |                              |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>restaurant</b>   |   | 13a. STREET ADDRESS / ZIP CODE<br><b>Route 6 Box 371/21502</b>   |                              |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Allegany</b>   |   | 13c. CITY OR TOWN<br><b>Cresaptown</b>   |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Keplinger</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hazel Millirons</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |                              |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-24-6668</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Ann Pratt, Cresaptown, MD - daughter</b>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intractable Congestive Cardiac failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ischemic Cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Digitalis Intoxication</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Digitalis Intoxication</b> |                              |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                              |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |                              |  |
| 22b. SIGNATURE<br><b>Dr. Ranjithan</b>   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12/27/85</b>  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Ranjithan</b>  |  | 22e. ADDRESS<br><b>Memorial Hospital Medical Bldg.<br/>Cumberland, MD 21502</b>  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12-29-1985</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph Cemetery</b>   |                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Midland Allegany MD</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>James F. Scarpelli, Cumberland, MD 21502</b>  |   |  |                              |  |
| 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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2002 NOV 05 1556

WOWA MITHRID



352016

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the Division of Vital Records, Department of Health and Mental Hygiene, Baltimore, Maryland. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |  |         |  |  |
|--|--|--|---|--|--|--|---------|--|--|
| 1 - STATE REGISTRAR  |  |  | REG. NO.  |  |  |  |         |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  |  | MONTH DAY YEAR   |         | 7b. HOUR   |  |
| Louise Bright Teter  |  |  | 12/11/85  |  |  |  | 7:05 AM |  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |         | IF UNDER 1 YEAR  |  |
| Female   |  | White  |   | June 30, 1906  |  | 79 YRS.  |         | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |         |  |  |
| W.VA.  |  | USA  |   |  |  | Allegany MD.   |         |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |         | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Cumberland   |  | 635 Apt. 4B Washington St.   |   |  |  | Housewife  |         | Own Home   |  |
| 13a. STATE   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |         | 13e. STREET ADDRESS / ZIP CODE                                 |  |
| Maryland   |  | Allegany   |   | Cumberland   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |         | 635 Apt. 4B Wash. St. / 21502                                  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                   |         |  |  |
| Charles E. Bright  |  |  | Lulah Katherine Rinehart  |  |  | 16b. SOCIAL SECURITY NO.   |         |  |  |
|  |  |  |   |  |  | 17. INFORMANT  |         |  |  |
|  |  |  |   |  |  | 4512 Hoban Road NW   |         |  |  |
|  |  |  |   |  |  | Washington, D.C.   |         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |  |  |  |         |  |  |
| IMMEDIATE CAUSE (a) <u>Cholera</u>   |  |  |   |  |  |  |         |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |  |  |         |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypocalcemia - substitution</u>  |  |  |   |  |  |  |         |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>M. Tuberc. Breast CA.</u>  |  |  |   |  |  |  |         |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |  |  |   |  |  |  |         |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?  |         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |         | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |         |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |         |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION  |         |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |   |  |  | STREET CITY OR TOWN COUNTY STATE   |         |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |         |  |  |
| 22b. SIGNATURE   |  |  | DEGREE  |  |  | 22c. DATE SIGNED   |         |  |  |
| <u>H. Merrick</u>  |  |  |   |  |  |  |         |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  |  |  |         |  |  |
| H. Merrick   |  |  | Merrick M.D.  |  |  | Cumberland, Maryland 21502   |         |  |  |
|  |  |  |   |  |  | 500 Memorial Hospital, Medical Bldg  |         |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |         | 23e. COUNTY  |  |
| Burial   |  | 12/13/85   |   | Queens Point Ceme.   |  | Keyser, Mineral, W. VA.  |         |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |  | 25b. REGISTRAR'S SIGNATURE   |         |  |  |
| NAME   |  |  | ADDRESS   |  |  |  |         |  |  |
| John J. Hafer, Jr. LaVale, MD  |  |  |   |  |  | DEC 16 1985  |         |  |  |

MEDICAL CERTIFICATION

100-100000

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John J. Harte, Jr. Leno, IL

Sum-I

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006152

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |  |  |   |  |
|--|--|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) MARY ELIZABETH TRAIL             |  |  | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 26 1985 |  |  | 2b. HOUR 2 AM M  |  |   |  |
| 3. SEX FEMALE  |  | 4. RACE WHITE  |   | 5. DATE OF BIRTH MONTH DAY YEAR MAY 11 1910  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.                        |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD   |  |   |  |
| 10. CITY OR TOWN OF DEATH LITTLE ORLEANS                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AT HOME RFD#1 |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |
| 13a. STATE MARYLAND  |  | 13b. COUNTY ALLEGANY   |   | 13c. CITY OR TOWN LITTLE ORLEANS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS RFD#1 20760                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST CECIL U. SCHRIVER                |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUSSCELLA HILL  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO |  |  |   | 16b. SOCIAL SECURITY NO. 218-60-1022   |  | 17. INFORMANT ADDRESS DARHL TRAIL STAR ROUTE FLINTSTONE MD 21530                             |  |   |  |

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 82, to NOV 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE Robertiano J. Barrera, Jr.  |  |   |  | DEGREE MD   |  | 22c. DATE SIGNED 12-26-85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ROBUSTIANO J. BARRERA  |  |   |  | 22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND                        |  |   |  |

|   |  |                       |  |  |  |  |  |
|---|--|-----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                  |  | 23b. DATE DEC29, 1985 |  | 23c. NAME OF CEMETERY OR CREMATORY PINEY PLAINS CEMETERY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE PINEY PLAINS ALLEGANY MARYLAND |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND |  |                       |  | 25a. DATE REC'D. BY REGISTRAR DEC 30 1985                |  | 25b. REGISTRAR'S SIGNATURE John Davidson-Bondell                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon copies of this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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2-20-51

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X

1-20-51



CHILDREN

50% COTTON

REF 30

007096

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |                                    |  |                        |  |
|---|--|--|---|--|------------------------------------|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |  |                                    | 2b. HOUR   |                        |  |
| Olive Jane Twigg  |  |  | 12 29 85  |  |                                    | 9:15 P.M.  |                        |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |                                    | 7. IF UNDER 1 YEAR   |                        |  |
| Female  | White  | Jan. 9, 1892   | 93 YRS.   |  |                                    | MONTHS DAYS HOURS MIN.   |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                    |  |                        |  |
| MD  | USA  |  | Allegany MD.  |  |                                    |  |                        |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |                        |  |
| Cumberland  | Lion's Manor Nursing Home  |  | Housewife   |  |                                    | Own Home   |                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13d. INSIDE CITY LIMITS?  |  |                                    | 13e. STREET ADDRESS / ZIP CODE   |                        |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  |   |  |                                    | Rt. # 1, 21524   |                        |  |
| MD  | Allegany   | Corriganville  | NO <input checked="" type="checkbox"/>                              |  |                                    |  |                        |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                    |  |                        |  |
| Charles Allen   |  |  | Florence A. Cassidy   |  |                                    |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |                                    | 17. INFORMANT ADDRESS  |                        |  |
| No  |  |  | 212-74-9809   |  |                                    | Gwendolyn McCray, Baltimore, MD  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |                                    |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |  |                                    |  |                        |  |
| IMMEDIATE CAUSE (a) Acute Myocardial Infarction   |  |  |   |  |                                    |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |                                    |  |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |                                    |  |                        |  |
| (b) Atherosclerotic Cardiovascular disease  |  |  |   |  |                                    |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |                                    |  |                        |  |
| (c)   |  |  |   |  |                                    |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |  |   |  |                                    |  |                        |  |
| Upper G.I. bleeding, Ventricular irritability   |  |  |   |  |                                    |  |                        |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    | 20a. AUTOPSY?  |                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |   |  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |                        |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |  |                                    |  |                        |  |
|   |  |  | P.M. 19   |  |                                    |  |                        |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION  |                        |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |   |  |                                    | CITY OR TOWN COUNTY STATE  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-29, 1983, to 12-29, 1985, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                    |  |                        |  |
| 22b. SIGNATURE  |  |  |   |  |                                    | DEGREE   |                        | 22c. DATE SIGNED   |
| V. A. Ranjithan   |  |  |   |  |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                        | 12-30-85   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  |                                    | 22e. ADDRESS   |                        |  |
| V. A. Ranjithan, M. D.  |  |  |   |  |                                    | L.M.N.H. Seton Drive, Cumberland, MD 21502   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION          |  |
| Burial  |  |  | Jan. 2, 1986  |  | Sunset Memorial p.                 |  | Cumberland Allegany MD |  |
| 24. FUNERAL DIRECTOR  |  |  |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |                        |  |
| William G. Kight Cumberland, MD   |  |  |   |  |                                    | 3 300  |                        |  |

007037



20% COTTON

Burial Jan. 2, 1986 Sunset Memorial P. Cumberland Allegany MD  
William G. Knight Cumberland, MD

No Gwendolyn McCray, Baltimore, MD  
Charles Allen Florence A. Cassidy  
MD Allegany Corrigansville x Rt. # 1, 21524  
Cumberland Lion's Manor Nursing Home Housewife Own Home  
MD USA  
Female White Jan. 2, 1932 93

008118

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 8 8 3

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |   | 2b. HOUR 10:02 P. M.  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>KATE D VANCE</b>  |  | December 28, 1985   |   |   |  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JAN 9 1902</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>83</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W.VA.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>----- |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>ALLEGANY</b>  | 13c. CITY OR TOWN<br><b>FLINTSTONE</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN DAY</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MYRA BRICKER</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-03-7170-D</b>  |   | 17. INFORMANT ADDRESS<br><b>EVELINE COLLIER RFD 1 FLINTSTONE MARYLAND</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>my cardiac infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASEVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12/27</b> , 19 <b>85</b> , to <b>12/28</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |
| 23a. SIGNATURE <b>Dr. William P. Iames</b>   |  |   |   | 23c. DATE SIGNED <b>12/29/85</b>  |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. William P. Iames</b>   |  | 23d. ADDRESS<br><b>441 N. Centre Street<br/>Cumberland, MD 21502</b>  |   | 23e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>31 DEC 1985</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FAIRVIEW CHRISTIAN CEM</b>   |  |
| 23d. LOCATION<br><b>INGLESMTTH BEDFORD PENNA.</b>  |  | 23e. DATE REC'D. BY REGISTRAR   |   | 23f. REGISTRAR'S SIGNATURE  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND</b>   |  |   |   |   |  |

MEDICAL CERTIFICATION

B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please destroy this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

821800



006204

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 8 8 4

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                                 |  |
|--|--|--|--|---|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDNA JANE WALTERS   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>December 21, 1985 |   | 2b. HOUR<br>7:10a. <sup>M</sup> |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JANUARY 5, 1915   |                                 |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS  |  | 7. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 9b. BALTIMORE CITY OR COUNTY OF DEATH<br>ALLEGANY MD.                                |  | 10. CITY OR TOWN OF DEATH<br>Cumberland   |                                 |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MEMORIAL HOSP. & MEDICAL CENTER   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>GROCERY  |                                 |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>ALLEGANY  |  | 13c. CITY OR TOWN<br>MT. SAVAGE   |                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM GRIFFITH   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CATHERINE HARTIG                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |                                 |  |
| 16b. SOCIAL SECURITY NO.<br>216-22-6692  |  | 17. INFORMANT<br>ADDRESS<br>CHARLES E. WALTERS, SAME AS 13c                          |  |   |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Chronic Obstructive Lung Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>N/A</u>  |  |  |  |   |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>N/A</u>  |  |  |  |   |                                 |  |
| 19a. DATE OF OPERATION<br><u>N/A</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>N/A</u>                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>N/A</u> 19                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><u>N/A</u>  |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>N/A</u> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>N/A</u>   |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/22/85</u> , 19 <u>85</u> , to <u>12/24/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/22/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |                                 |  |
| 22b. SIGNATURE<br><u>Dr. James Raver</u>   |  |  |  | 22c. DATE SIGNED<br><u>12/24/85</u>   |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. James Raver   |  |  |  | 22e. ADDRESS<br>Memorial Hospital Medical Bldg.<br>Cumberland, MD 21502   |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>DEC. 23 '85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>METHODIST CEMETERY  |                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MT. SAVAGE, ALLEGANY, MD.  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>DURST FUNERAL HOME, FROSTBURG, MD. 21532     |  |   |                                 |  |
| 25a. DATE REC'D. BY REGISTRAR<br>DEC 31 1985   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson Rouse</u>  |                                 |  |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it from pages 1 and 2 and file it within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO THE HONORABLE SECRETARY OF THE ARMY  
WASHINGTON, D. C.  
FROM THE HONORABLE SECRETARY OF THE ARMY  
WASHINGTON, D. C.  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or letter body.]

1



364131

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |  |   |   |   |  |  |   |  |  |  |
|--|--|---|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MABEL MARGIE WATKINS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 11, 1985</b>               |   |  | 2b. HOUR<br>7:50 P.M.  |   |  |  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05-22-1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USa</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.                          |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Memorial Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>Allegany</b>  |   | 13c. CITY OR TOWN<br><b>Cumberland</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>814 Sylvan Avenue/21502</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James R. Stump</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Belle Robey</b>       |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-14-7476</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Robert S. Watkins, Cumberland, MD - son</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular event</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>SD Hemorrhage</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Uremic gastritis gastritis</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>pneumonia</u> |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u> |  |
|  |  |   |   |   |  |  |   |  | <u>1-2h</u>  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)   |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>12-11</u> , 19 <u>85</u> , to <u>12-11</u> , 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>12-11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Terry Williams</u>  |  |   |   | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   | 22c. DATE SIGNED<br><u>12-12-85</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Terry Williams</b>   |  |   |   | 22e. ADDRESS<br><b>Memorial Hospital Medical Bldg.<br/>Cumberland, MD 21502</b>   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12-14-1985</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland Allegany MD</b>          |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James F. Scarpelli, Cumberland, MD 21502</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 18 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Burton-Ponder</u>                             |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



013099

Shaffers Funeral Home  
 1. FOR STATE REGISTRAR 230 E. Main Street  
 Romney, WV 26757  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 5 3 2 8 8 0

REG. NO.

|  |  |  |  |   |  |   |  |                                   |   |                                   |  |
|--|--|--|--|---|--|---|--|-----------------------------------|---|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Max Eugene Waye |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>December 31, 1985 |   |  | 2b. HOUR<br>3:40A M   |  |                                   |   |                                   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 17 1928  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS |   | 8. IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>Indiana                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany County, MD.                    |  |                                   |   |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sacred Heart Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Service Man |  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U. S. Navy |                                   |  |

|   |  |  |                          |   |                             |  |   |  |   |  |  |
|---|--|--|--------------------------|---|-----------------------------|--|---|--|---|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>WV |  |  | 13b. COUNTY<br>Hampshire |   | 13c. CITY OR TOWN<br>Romney |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>P. O. Box 339 99999 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Silas Waye  |  |  |                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanche Marie Waye               |                             |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                 |  |  |                          | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>World War II 310248519 |                             | 17. INFORMANT<br>ADDRESS<br>Constance K. Way P. O. Box 339, 26757 Romney, WV |   |  |   |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Lung Cancer

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

8 months

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
 gave rise to immediate  
 cause (a), stating the  
 underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|                        |  |  |  |  |  |   |  |
|------------------------|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|------------------------|--|--|--|--|--|---|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|--|--|--|--|--|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |  |
|--|--|--|--|---|--|

22a. I certify that (I) (this hospital) attended the deceased from 12/19/85 to 12/31/85, that (I) (we) lost  
 saw the deceased alive on 12/31/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
 above. (I) (we) (did) (did not) view the body after death.

|   |  |              |  |                              |  |
|---|--|--------------|--|------------------------------|--|
| 22b. SIGNATURE<br>Richard Schmitt, M.D. |  | DEGREE<br>MD |  | 22c. DATE SIGNED<br>12/31/85 |  |
|---|--|--------------|--|------------------------------|--|

|  |  |  |  |
|--|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Schmitt, M.D. |  | 22e. ADDRESS<br>Dept Of Pulmonary Medicine, SHH, Cumberland Md |  |
|--|--|--|--|

|   |  |                     |  |  |  |  |  |
|---|--|---------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation |  | 23b. DATE<br>1/1/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Omps Cremation Service |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Winchester Frederick Va. |  |
|---|--|---------------------|--|--|--|--|--|

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br>Keith S. Shaffer |  | ADDRESS<br>Shaffer Funeral Home, Romney, WV |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1986 |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall |  |
|--|--|---|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this certificate to the funeral director's pages. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 3.

THE UNIVERSITY OF CHICAGO  
LIBRARY  
130 E. 5th Street  
CHICAGO, ILL. 60607

02-1033

November 21, 1967

Dr. J. H. ...

Chicago, Illinois

Chicago, Illinois

CHICAGO



100 ...

Dept. of Refractory Medicine, 214 Oakland

Chicago, Ill.



RECEIVED  
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from the front



353052

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |  |   |  |  |
|---|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RANSOM C WERTZ</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>DECEMBER 8, 1985</b>            |   | 2b. HOUR<br><b>12:00 P.M.</b>  |  |   |  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04-25-1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>PA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEMORIAL HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>textile</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>Allegany</b>  |   | 13c. CITY OR TOWN<br><b>Cumberland</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Valentine Wertz</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Arrena T. Bennett</b> |   |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>307 Jefferson Street/21502</b>                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-10-6555</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Goldie M. Lewis-Greenspring, WV</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardio Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Sepsis due to Pneumonia, probably UTI + Cerebellitis</b><br>(c) <b>Severe malnutrition and Chronic Anemia</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/8/1985</b> to <b>12/8/1985</b> that (I) (we) last saw the deceased alive on <b>12/8/1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |  |
| 72b. SIGNATURE<br><b>Dr. Nathan</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 72c. DATE SIGNED<br><b>12/10/85</b>  |   |  |  |
| 72d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. NATHAN</b>  |  |   |   | 72e. ADDRESS<br><b>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502</b>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12-11-1985</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chaneyville Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Chaneyville PA</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>James F. Scarpelli, Cumberland, MD 21502</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 16 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia K. [Signature]</b>  |   |  |  |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return completed page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic cause, the medical examiner must be notified before the body is released for burial or cremation.





353124

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>LUCY MARIE WHETZEL   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>December 7, 1985                        |  | 2b. HOUR<br>4:00 pm  |  |
| 3. SEX<br>female   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>09-04-1913   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Memorial |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tire Co.  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>12807 Bunting Street S.W./21502           |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Clyde A. Ballow   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Kate M. Powell  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-14-6847  |  | 17. INFORMANT ADDRESS<br>Mr. John W. Whetzel, Cumberland, MD - son  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u><br><u>2 day</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>acute MI; operation</u>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that <u>Dr. Bollino</u> (this hospital) attended the deceased from <u>12-5</u> , 19 <u>85</u> , to <u>12-7</u> , 19 <u>85</u> , that <u>(we)</u> last saw the deceased alive on <u>12-5</u> , 19 <u>85</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Dr. Bollino</u>   |  |   |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>12-10-85</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Bollino   |  |   |  | 22e. ADDRESS<br>955 Frederick St.<br>Cumberland, MD 21502   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12-10-1985   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Marys Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland Allegany MD        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James F. Scarpelli, Cumberland, MD 21502   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 12 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson</u>                         |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, pages 1 and 2, and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REMARKS: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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20X COLICM 4115

WINTER 1941



1941-1942

360028

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO.   |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bertram F Whisler</b>  |  |  |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>12 9 19 85</b>                   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>June 25 1927</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>58</b>  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>12 12 19 85</b>            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY</b> MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lumberland</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Residence</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STATISTICIAN - U.S. GOVERNMENT</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>21502- Md. Allegany</b>  |  | 13b. COUNTY<br><b>Cumberland</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>427 N. Centre Street / 21502</b>   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Russel Whisler</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise Hummel</b>   |  |  |  | 17. INFORMANT<br><b>Edna Whisler Gaithersburg, Maryland</b>                          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>--</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>201-16-3285</b>  |  | 17. INFORMANT ADDRESS<br><b>17101 Queen Victoria Ct Gaithersburg, Maryland</b>                         |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                          |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Francisco Reyes</b>   |  |  |  | TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>12-12-85</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Francisco Reyes</b>  |  |  |  | ADDRESS <b>900 Seton Dr. Cumberland Md. 21502</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>12-14-85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale Funeral Chapel</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Martinsburg - BERKELEY - W. Va.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>George-Upchurch Funeral Home, P.A.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 23 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| 202 Green Street, Lumberland, Md. 21502   |  |  |  |   |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

1. Name of the plant: *...*

2. Locality: *...*

3. Date: *...*

4. Collector: *...*

5. Description: *...*

6. Uses: *...*

7. Remarks: *...*

8. Distribution: *...*

9. Cultivation: *...*

10. Other: *...*

RECEIVED  
OCT 10 1910



353057

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial. Retention of this certificate after removal is prohibited.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| SILCOX-MERRITT FUNERAL HOME   |  |   |  | STATE OF MARYLAND   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR 404 Decatur Street<br>STATE REGISTRAR CUMBERLAND, MD 21502   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |
|   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| Jennie Josephine Wilson   |  |   |  | December 11, 1985   |  |  |  |
| 3. SEX  |  |   |  | 2b. HOUR  |  |  |  |
| FEMALE  |  |   |  | 10:50PM   |  |  |  |
| 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. UNDER 1 YEAR  |  |
| WHITE   |  | MONTH DAY YEAR<br>SEPT 7 1930   |  | 55 YRS.   |  | MONTHS DAYS HOURS MIN.   |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 11. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| MARYLAND  |  | USA   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany County, MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| CUMBERLAND  |  | Sacred Heart Hospital   |  | McCROYS DEPT STORE CLERK  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS?  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |
| MARYLAND  |  | ALLEGANY  |  | CUMBERLAND  |  | 537 FAIRVIEW AVE CUMBERLAND MD. 21502                          |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| FIRST MIDDLE LAST<br>JOHN PULLEM  |  |   |  | FIRST MIDDLE LAST<br>MANDA (UNK)  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |  |  |
| NO  |  | 215267110   |  | WILLIAM WILSON 537 FAIRVIEW AVE CUMBERLAND MD.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic End Stage Adenocarcinoma of Pancreas</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <i>G. Wagoner M.D.</i>   |  |   |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gary Wagoner, M.D.   |  |   |  | 22e. ADDRESS<br>925 Bishop Walsh Road, Cumberland, MD 21502   |  | 12-13-85   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL   |  | 23b. DATE<br>DEC 16 1985  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ROCKY GAP VETERANS CEMT FLINTSTONE ALLEGANY MD  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND  |  |   |  | 25. BY REGISTRAR<br>DEC 18 1985<br>REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodden</i>   |  |  |  |

34307

604 Locating Street  
Ottawa, Ont. K1P 1B2

10:55 AM December 11, 1982 Wilson

Allegany County

Second Street

RESERVED



255 Prince of Wales Road, Ottawa, Ont. K1P 1B2

Gen. 1-800-367-8282

DEC 18 1982



353144

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |                                     |  |  |
|---|--|--|--|--|-------------------------------------|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>RETA VIRGINIA WILSON</b>   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>DECEMBER 7, 1985</b> |  | 2b HOUR<br><b>3:10P<sub>M</sub></b> |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>JUNE 28 1901</b>  |                                     | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.<br><b>84</b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. VA.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>ALLEGANY COUNTY MD.</b>  |  |
| 10 CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SACRED HEART HOSPITAL</b> |  |  |                                     | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                       |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>SCHOOL TEACHER</b>   |  |  |  |  |                                     |  |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>ALLEGANY</b>  |  | 13c CITY OR TOWN<br><b>CUMBERLAND</b>  |                                     | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e STREET ADDRESS / ZIP CODE<br><b>3 VALLEY ROAD 21502</b>   |  |  |  |  |                                     |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>MILLARD F. BARTLETT</b>  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>VIRGINIA CARTWRIGHT</b>  |  |  |                                     |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b SOCIAL SECURITY NO.<br><b>217-54-6295</b>  |  | 17 INFORMANT ADDRESS<br><b>OSCAR WILSON RFD# 3 VALLEY ROAD CUMBERLAND MD.</b>  |                                     |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recent acute MI</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Atherosclerosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hr.</b><br><b>1 mo.</b><br><b>years</b> |  |  |  |  |                                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>Pneumonitis</b>  |  |  |  |  |                                     |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |                                     |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |                                     |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>Dec. 1</b> , 19 <b>85</b> , to <b>Dec. 7</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |                                     |  |  |
| 22b SIGNATURE<br><b>V. Eugene Mazzocco</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |                                     | 22c DATE SIGNED<br><b>12/10/85</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V. EUGENE MAZZOCCO - Dr Miles</b>  |  | 22e ADDRESS<br><b>BMG, 912 SETON DRIVE CUMBERLAND, MD 21502</b>  |  |  |                                     |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b DATE<br><b>DEC 11 1985</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>SUNSET MEMORIAL PARK</b>   |                                     | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>CUMBERLAND ALLEGANY MARYLAND</b>  |  |
| 24 FUNERAL DIRECTOR NAME<br><b>SILCOX-MERRITT FUNERAL</b>   |  | ADDRESS<br><b>HOME CUMBERLAND MARYLAND</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>DEC 13 1985</b>   |                                     | 25b REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove class 1 pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B, then any injury, or other traumatic event, the medical examiner must be notified at once.

3501 N

3:10P

DECEMBER 7, 1982

WILSON

VIRGINIA

RETN

ALLEGANY COUNTY

SACRED HEART HOSPITAL

817-24-4295



X

W.C. 912 SEYM DRIVE  
CUTLERLAND, MD 21502

V. EUGENE WATKINS

DEC 13 1982  
FBI - ALLEGANY COUNTY

361021

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |   |  |  |                                 |   |  |
|---|--|---|--|--|---------------------------------|---|--|
| 1 DECEASED NAME (TYPE OR PRINT)<br>JOHN DANIEL WINTERS  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>DECEMBER 19, 1985        |  | 2b. HOUR<br>10:00A.M.           |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>January 31, 1927  |                                 | 6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Allegany MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>CUMBERLAND  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Kelly-Springfield   |                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tire Company   |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Allegany                                      |  | 13c. CITY OR TOWN<br>Cresaptown |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Osbey - Winters  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mae - Phillips |  |                                 |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO<br>W.W.II 216-22-6754   |  | 17. INFORMANT ADDRESS<br>Merle L. Winters-Address same as #13 above.   |                                 |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PULMONARY EMBOLISM</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>PULMONARY INFARCTION</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PERFORATING PEPTIC ULCER</u> |  |   |  |  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                 |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                 |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-28</u> , 19 <u>85</u> , to <u>12-15</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>11-13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |                                 |   |  |
| 22b. SIGNATURE<br><u>DR. TORRES</u>   |  |   |  | DEGREE<br>MD   |                                 | 22c. DATE SIGNED<br>12/19/85  |  |
| 22d. PHYSICIAN (NAME) (TYPE OR PRINT)<br>DR. TORRES   |  |   |  | 22e. MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502   |                                 |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12-21-85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Hillcrest Burial Park  |                                 | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Cumberland-Allegany Co., -Md.  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>George-Upchurch Funeral Home, P.A.<br>202 Greene Street-Cumberland, Maryland 21502   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 24 1985   |                                 |   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |                                 |   |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



364155

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THE DEATH CERTIFICATE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMH - 17  
(VR A15 ME (5))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |   |  |   |  | REG. NO. 5 3 2 8 9 4   |  |
|---|--|-------------------------|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                         |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Mary Alice Wolford</b>  |  |                         |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>12 20 1985</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 21, 1898</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>87</b>                          |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>12 20 1985</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Allegany</b> MD.  |  |
| 11. CITY OR TOWN OF DEATH<br><b>Cumberland</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sacred Heart Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>   |  |
| 13a. STATE<br><b>W. Va.</b>   |  |                         |  | 13b. COUNTY<br><b>Mineral</b>  |  | 13c. CITY OR TOWN<br><b>Keyser</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13. STREET ADDRESS<br><b>500 Carskadon Lane</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles W. McKenzie</b>  |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Ann Fleek</b>    |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>234 44 6625</b>   |  | 17. INFORMANT ADDRESS<br><b>Carl Wolford Rt 1 Box Chandler, Texas</b>         |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Giovanni Mastrangelo</b>  |  |                         |  |  |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  | MEDICAL EXAMINER  |  | DATE SIGNED <b>12-20-85</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo, M.D.</b> ADDRESS <b>900 Seton Drive, Cumberland, MD 21502</b>  |  |                         |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>23 Dec 85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Queens Point</b>                     |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Keyser Mineral W. Va.</b>                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Allen Rotruck Keyser, W.Va.</b>   |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 26 1985</b>                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

BP

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102594

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by W. Jansin



340132

1- FOR  
STATE  
REGISTRAREichhorn Funeral Home  
Main Street  
Lonaconing, MD 21539  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 8 7 5

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST Helen MIDDLE Cecelia LAST Woods  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>12-01-85   |  | 2b HOUR<br>8:57M   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>Sept. 11 <sup>th</sup> , 1918                                     |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>67   |  | 7a BIRTHPLACE<br>(STATE OR FOREIGN)<br>MD   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>allegany county MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Cumberland   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sacred Heart Hospital                           |  | 12a USUAL OCCUPATION<br>(IF NOT WORKING, GIVE MOST RECENT WORKING LIFE)<br>Homemaker |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br>Home   |  | 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE MD 13b COUNTY Allegany 13c CITY OR TOWN Lonaconing |  |  |  |
| 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e STREET ADDRESS / ZIP CODE<br>2 St. Marys Terrace 21539  |  |  |  |
| 14 FATHER'S NAME<br>FIRST Terence MIDDLE T. LAST Woods   |  | 15 MOTHER'S MAIDEN NAME<br>MIDDLE Frances LAST Grimes   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO<br>None  |  | 17 INFORMANT ADDRESS<br>Cumberland<br>Frances Lipphold Rt8, Box 152 Md               |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *cardiac arrest*

DUE TO, OR AS A CONSEQUENCE OF

(b) *myocardial infarction*

DUE TO, OR AS A CONSEQUENCE OF

(c) *arteriosclerotic cardiovascular disease*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

5 minutes

48 hrs

may yr

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *none*

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                     |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-30</i> , 19 <i>85</i> , to <i>1-1</i> , 19 <i>85</i> , that (I) (we) lost<br>saw the deceased alive on <i>12-30</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b SIGNATURE<br><i>Donald Manger</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>12-28-85</i>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donald Manger, M.D.   |  |  |  | 22e ADDRESS<br>55 Jackson Street, Lonaconing, MD   |  |  |  |

|   |  |                          |  |   |  |  |  |
|---|--|--------------------------|--|---|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b DATE<br>Dec. 4, 1985 |  | 23c NAME OF CEMETERY OR CREMATORY<br>Sunset Mem. Park |  | 23d LOCATION<br>Cumberland Allegany MD 21539 |  |
|---|--|--------------------------|--|---|--|--|--|

|   |  |  |  |                           |  |
|---|--|--|--|---------------------------|--|
| 24 FUNERAL DIRECTOR<br>Eichhorn Funeral Home, Lonaconing, Md. |  | 25a DATE RECEIVED BY REGISTRAR<br>DEC 4 1985 |  | 25b REGISTRAR'S SIGNATURE |  |
|---|--|--|--|---------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



316133

8:35

11-01-82

Wooda

Cecil's

Walen

alligany county

USA

Spaced Bears Hospital

Illigany B. on-coming

213133040

Thomas Hanger, W.D.

22 Madison Street, Indianapolis, IN